

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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
--------------------	--	---------------	---	----------------------

R000000	<p>This visit was for the State Residential Licensure Survey.</p> <p>Survey dates: May 28, 29 and 30, 2014.</p> <p>Facility number: 002999 Provider number: NA AIM number: NA</p> <p>Survey team: Sandra Nolder, RN-Team Coordinator Gloria Bond, RN</p> <p>Census bed type: Residential: 97 Total: 97</p> <p>Census payor type: Other: 97 Total: 97</p> <p>Sample: 10</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on June 4, 2014.</p>	R000000	<p><u>DISCLAIMER:</u></p> <p><u>Preparation and implementation of this plan of correction does not constitute admission or agreement by (facility name) of the truth of the facts, findings, or other statements as alleged by the preparer of the survey/inspection dated May 30, 2014. The Hearth at Windermere specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action not related directly to the licensing and/or certification of this facility or provider. The facility reserves the right to challenge the findings by way of independent review procedures established by the agency.</u></p>	
R000093	410 IAC 16.2-5-1.3(j)(1-4) Administration and Management -			

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:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>Noncompliance</p> <p>(j) If professional or diagnostic services are to be provided to the facility by an outside resource, either individual or institutional, an arrangement shall be developed between the licensee and the outside resource for the provision of the services. If a written agreement is used, it shall specify the following:</p> <p>(1) the responsibilities of both the facility and the outside resource;</p> <p>(2) the qualifications of the outside resource staff;</p> <p>(3) a description of the type of services to be provided, including action taken and reports of findings; and</p> <p>(4) the duration of the agreement.</p> <p>Based on interview and record review, the facility failed to ensure laboratory tests were drawn for 1 of 4 residents reviewed for laboratory services. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1's record was reviewed on 5/29/14 at 10:30 A.M. Diagnoses included, but were not limited to, weight loss, anemia, hypothyroidism and osteoporosis.</p> <p>A Physician order dated 5/21/14, indicated the resident was to have laboratory tests for a CBC (Complete Blood Count) with Differential (Test checks for bleeding and infection), BMP (Basic Metabolic Panel) (Test checks for</p>	R000093	1 The corrective action for the resident affected was the lab tests that were ordered were refaxed to the lab on 5/29/14 and a confirmation received stating the lab test request had been successfully transmitted The labs were drawn the morning of 5/30/14 and faxed to the physician that same morning for his review 2 To identify any other residents that may be affected by this type of issue, the Director of Nursing will review the labs orders in each chart for the last 30 days and verify that all orders faxed were successfully transmitted 3 Nursing staff will be trained ON how to use the fax and reminded to check to make sure all orders are successfully transmitted The fax machine will be labeled with a reminder to all staff using the machine to verify that the item faxed was actually	06/30/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>electrolytes and blood sugar), and Hepatic Function (Test checks the liver function.)</p> <p>A "Laboratory Order Fax Form Extended Care Facilities" was dated for 5/22/14 as the DOS (Date of Service). The laboratory tests marked on this form were Hepatic Function, BMP and CBC with Differential.</p> <p>An "Error TX [Transmission] Report" dated 5/21/14, at 14:05 (2:05 P.M.) indicated the transmission function was not completed and 0 pages were sent. The page that was attempting to be sent showed a copy of the "Laboratory Order Fax Form Extended Care Facilities" dated for 5/22/14, as the DOS (Date of Service). The laboratory tests marked on this form were Hepatic Function, BMP and CBC with Diff.</p> <p>During an interview on 5/29/14 at 2:00 P.M., the Director of Nursing indicated the laboratory tests ordered on 5/21/14 for this resident were scheduled to be drawn on 5/22/14 and were faxed to the laboratory on 5/21/14. She indicated the fax with the laboratory tests did not go through to the laboratory and no one noticed until now when the issue was brought to her attention, so the laboratory tests were not drawn on the resident.</p>		<p>transmitted 4 This will be monitored by the 11-7 charge nurse daily and weekly by the Director of Nursing. Nursing has an accordion file of all the lab orders, by date due and the 11-7 charge nurse can monitor each day's additions to the file to make sure the orders were properly transmitted. The 24 hour report will be update to remind the 11-7 charge nurse to check the accordion file daily. 5. This will be corrected by June 30, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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
R000151	<p>A current policy titled "LABORATORY AND RADIOLOGIC SERVICES" dated 9/20/01, provided on 5/30/14 at 10:10 A.M., by the Executive Administrator (ED) indicated, "Purpose: To ensure that appropriate diagnostic services are available to the residents and to outline the responsibilities of outside resources and facility staff. Responsibility: Administer, Director of Nursing, Personal Care Staff and Laboratory Services. Policy: It is the policy [name of the facility] to provide or make arrangements for prompt laboratory, X-ray and other diagnostic services for all residents...."</p> <p>410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. Based on observation, interview and record review, the facility failed to recognize the existence of a pet cat for a resident, and failed to have the cat examined and receive the required immunizations for the pet 1 of 9 pets regularly residing in the facility. (</p>	R000151	<p>1 The cat was immediately taken to the veterinarian and the shots were updated 2 All of the pet records were reviewed by the Executive Director to ensure they were up to date and they were all current 3 To make sure this will not</p>	06/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>Resident #10's cat)</p> <p>Findings include:</p> <p>During an interview on 5/29/2014 at 11:25 A.M., with Resident #10, a small gray and white mix cat was observed coming in to see the resident from the resident's bedroom. The resident indicated her family had given her the cat to keep her company.</p> <p>In an interview on 5/29/2014 at 3:05 P.M., the Business Office Manager indicated Resident #10 did not have a cat in her apartment that the facility knew about.</p> <p>On 5/29/2014 at 3:10 P.M., a small gray and white cat was observed in the resident's room with the Business Office Manager in attendance. At this time, the resident indicated that she has had the cat since she moved in a few months ago.</p> <p>During an interview with the Business Office Manager at this time, she indicated she would call the family to get the shot records.</p> <p>In an interview on 5/29/2014 at 4 P.M., the Executive Director indicated they had a 3 tier system of checking what pets were living in the facility. She was not</p>		<p>happen in the future, all new residents will be asked if they have a pet when signing admission paperwork This will be noted on the preadmission form and the records will be required prior to the resident being admitted The date the pet records are due will be calendared in Outlook at the reception desk and a reminder to the Executive Director a month before the immunizations are actually due.</p> <p>4. The Executive Director or designee will check the calendar monthly for any immunizations that are due and call the families or resident if the update shots are not provided.</p> <p>5. This will be corrected by June 30, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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
R000214	<p>sure how that system broke down, but at this point the family was contacted and the pet was being seen by a Veterinarian today.</p> <p>The facility's Pet Policy dated 5/08, was reviewed on 5/29/2014 at 3:15 P.M. The policy indicated the following: "Purpose: To ensure a safe environment for residents, employees and visitors in accordance with state law... All pets housed in the facility shall have periodic veterinary examinations and required immunizations. A copy of these records shall be kept on file in the Executive Director's office...."</p> <p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to evaluate the individual needs of a resident related to significant changes in condition for 1 of 10 residents reviewed for changes in</p>	R000214	<p>1. The resident's careplan was updated to reflect the resident's current issues and physician orders 2 All residents have the potential to be affected so the Director of Nursing will review the residents</p>	07/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>condition. (Resident #1)</p> <p>Findings include:</p> <p>Resident #1's record was reviewed on 5/29/14 at 10:30 A.M. Diagnoses included, but were not limited to, senile dementia of Alzheimer's type, history of urinary tract infections, weight loss, anemia, osteoporosis and hypothyroidism.</p> <p>A Physician progress note dated 11/20/13, indicated "...Diagnoses:..Weight loss...HPI [History Physical Information] comments:..Appetite poor...Dioes [sic] not take supplements well...Assessment:..2. Weight loss...Plan:..Re-evaluate in 2 weeks. May need to consider appetite stimulant such as Megace [An appetite stimulant medication] or mirtazapine [An antidepressant medication]."</p> <p>A Physician progress note dated 12/4/13, indicated, "...Diagnoses: ...Depression...Weight loss, unintentional... Medications Ordered This Encounter: mirtazapine (Remeron) [An antidepressant medication] 15 mg [milligrams] tablet. Take 1 tablet (15 mg total) by mouth Nightly.- Oral...HPI Comments:..APPETITE STILL NOT</p>		<p>current condition and compare it to the service plan to make sure the plan reflects the resident's current condition</p> <p>3 The Director of Nursing will receive a copy of all physician orders to make sure the careplans are updated with new orders and will review the 24 hour report daily to monitor for changes of condition and will update the service plan or care plan as needed</p> <p>4 Director of Nursing will meet with nursing staff each morning for an update on any changes in condition of residents All Staff will be reminded to use care alert forms to inform Director of Nursing of any changes in condition</p> <p>5 This will be corrected by July 5, 2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>GOOD. ADMITS TO DEPRESSED MOOD...WEIGHT DOWN TO 77 LBS [pounds] FROM 86 LBS ON 10/26/13...Physical Exam:...Conjunctivae pale...Psychiatric: Her mood appears not anxious. Cognition and memory are impaired. She exhibits a depressed mood (MILDLY) ...Assessment:...Depression ...Weight loss...Plan: Add Remeron 15 mg q [every] hs [bedtime]--watch for drowsiness, Continue Citalopram [An antidepressant medication]...Continue supplements...."</p> <p>A Physician progress note dated 3/5/14, indicated "Diagnoses:...Depression ...Progress notes:...Appetite improved [sic] weight up 5 lbs in last month. Remains on Remeron--mood stable..."</p> <p>A Physician progress note dated 4/30/14, indicated "Diagnoses: Rash, skin, Decubitus ulcer of perianal region, Stage I, Gait instability, Physical deconditioning, Urinary Incontinence...HPI comments: Has persistent buttocks erythema and soreness. Spends much of day in chair reading or doing crossword. Denies B/B [bowel or bladder] incontinence...Currently using Riley butt cream [A medicated incontinent barrier protectant] as barrier protectant...Physical Exam:...Macerated, erythematous [sic]</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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>skin buttocks with areas of superficial breakdown...Psychiatric: Cognition and memory are impaired. Assessment: Buttocks rash/skin breakdown, History of incontinence, Deconditioning...Plan: Check resident every 2 hours to ensure dryness, Encourage increased ambulation, Calmoseptane [sic] [incontinent cream barrier protectant] to buttocks bid [twice daily] and prn [as needed], Continue supplements, PT [Physical Therapy] for gait assistance, strengthening, improve endurance...."</p> <p>The resident's weights were as follows: October 2013--87 November2013--86 December 2013--78 January 2014--80 February 2014--82 March 2014--84 April 2014--84 May 2014--82</p> <p>A document titled "Integumentary Status" for a wound care nurse visit for 5/23/14, indicated the resident had a current Stage I pressure ulcer to her buttocks that measured 18.0 x 15.0 x 0 cm (centimeters). There was no drainage, odor or undermining, but inflammation was present. The onset date for the ulcer was 2/1/14. The document indicated the area was red, dry and excoriated. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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 was applying Calmoseptine cream. The note indicated the resident did not have a pressure relieving device in place and she was at risk for developing pressure ulcers.</p> <p>The resident had a Service Plan dated 11/25/13, that indicated, "...2.Nurse Evaluation: Bladder: to be clean and dry, "dribbles"-wears pads for protection...3. Medical History:...Urinary Tract problems:...monitor for any behavioral changes...6. Observation/Interview Information: mental Health (thought disorder& mood problems)...Description of general mood/behavior...does not voice c/o [complaints of] sadness or depression, smiles often and is sociable...12. Health Monitoring...Weigh resident (in addition to monthly wellness check)...weight to be checked weekly...13. Skin Integrity: Perform Basic wound care...[name of home health care company] follows all wound care issues...16. Eating and Dietary... Dietary information: since bout with shingles, resident has had decreased appetite, takes nutritional supplement and physician is aware of loss of appetitive recently, staff encouraging fluid and meal consumption...."</p> <p>The resident had a Service Plan dated 05/07/14, that indicated, "...2. Nurse</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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>Evaluation: Bladder: to be clean and dry, "dribbles-wears pads for protection...Depression: hx [history] depression...Urinary Tract problems:... monitor for any behavioral changes...6. Observation/Interview Information: Mental Health (thought disorder & mood problems) Resident currently suffers from depression: resident has a dx. [diagnosis] of depression, however, she does not voice c/o sadness or depressive feelings...12. Health Monitoring: Weight resident (in addition to monthly wellness check)...weight to be checked weekly on Saturday...13. Skin Integrity: Perform basic wound care: [name of home health care agency] follows all wound care issues, staff will notify them if needing intervention from wound care...16. Eating and Dietary:...Dietary information: resident receives reminders to come to the dining room for meals, appetite is good...20. Bowel and Bladder: Resident is independent with toileting: toilets self and completes own peri care, she wears pad due to "dribbling" Details: No services needed. Incontinent of bowel/bladder: "dribble"-wears pads for incontinence protection...."</p> <p>A current undated policy titled "PERSONAL CARE SERVICES POLICY" indicated, "Purpose: To ensure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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>that each resident is provided personal care and supervision based on individual need...Policy: It is the policy of [name of the facility] at each resident shall receive personal care and supervision in accordance with facility standards and the physician's medical care plan...7. Residents who develop bowel or bladder incontinency will be assessed to determine the need for medical intervention or other measures to promote continued independence. Personal care staff will provide instruction and assistance to the resident in maintenance of personal hygiene. 8. Resident's who use incontinency products shall be monitored closely to prevent skin breakdown of unsanitary conditions...13. Residents shall be assessed every six months by a licensed nurse to identify individual needs. The assessment shall include ADL's [Activity of Daily Living], nutritional and hydration status...weight...."</p> <p>During an interview on 5/29/14 at 1:48 P.M., CNA #2 indicated the resident required assistance with personal hygiene care, grooming, dressing, cleaning her dentures, and CNA #2 applied moisture barrier cream to the resident's inner buttocks after personal hygiene. She indicated she assisted her to ambulate to meals due to she had to be reminded</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>when meals were. She indicated she ate approximately 75% of breakfast and 50% or less of lunch. She drank 100% of her supplement.</p> <p>CNA #2 indicated the resident was incontinent of her bladder at times and she completed every two hour incontinent checks on her. She indicated the resident does well getting to the restroom independently, but there were times when she waited to long and her brief was wet. She indicated she gave her incontinence care and applied the moisture barrier cream.</p> <p>During an interview on 5/30/14 at 12:00 P.M., the Director of Nursing (DoN) indicated she was not aware of the resident's depressed mood or her change in toileting needs. She indicated the Physician visited the residents then dictated his note and the notes were sent to the facility, so she may not have made a new service plan after a Physician visited a resident and she would not have known about a change in condition from the progress notes. She indicated she did not see the Physician progress notes that indicated the resident had a weight loss after the service plan was made on 11/25/14.</p> <p>The DoN indicated the resident's</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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
R000217	<p>depressed mood, start of the Remeron medication (An antidepressant medication), change in the resident's toileting needs, stage I pressure ulcer, weight loss and deconditioning with a PT (Physical Therapy) and OT (Occupational Therapy) order should have been placed on the resident's service plan as a change of condition or a new service plan should have been initiated. She did not indicate how the resident was being monitored for drowsiness while on the Remeron or for behavioral changes as stated in her service plan.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure service plans were completed in a timely manner, signed and updated as resident's individual needs changed for 3 of 10 residents reviewed for service plans. (Residents #3, #6 and #7)</p> <p>Findings include:</p> <p>1. Resident #3's record was reviewed on 5/29/14 at 5:10 P.M. Diagnoses included, but were not limited to, dementia, agitation, Alzheimer's disease, osteoarthritis and gait disturbance.</p> <p>On 5/29/14 at 4:00 P.M., the resident was observed sitting at a table in the activities room. She was attempting to</p>	R000217	<p>1 To correct the items noted the resident's careplans were updated to reflect resident #3 spoke a foreign language and #7 resident has a pacemaker and receives pacemaker checks</p> <p>2 The Director of Nursing will review all service plans for all residents to make sure they are in the file, signed, and up to date</p> <p>3 The Director of Nursing will update careplans based upon evaluations upon admission and every 6 months or during a change of condition Family or resident's unable to attend careplans in person will be called to discussed the careplan and if still not available the care plan will be mailed/given to the family member/resident with a request to return the signed care plan or the plan will be sent for electronic signature</p> <p>4 The Director of Nursing will</p>	07/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>communicate with another resident. Her speech was intelligible (fluent) words, but she was not speaking English. She was most likely speaking a foreign language.</p> <p>A nurses' note dated 3/20/14 at 11:00 A.M., indicated the resident will respond when spoken to, but she often will respond back in "Swedish."</p> <p>A nurses' note dated 3/30/14 at 10:00 A.M., indicated the resident can speak "English", but she preferred to speak "French the country she is from."</p> <p>A nurses' note dated 5/3/14 at 9:30 P.M., indicated the resident will speak "English", but she spoke "French" mostly.</p> <p>A nurses' note dated 5/23/14 at 1:00 P.M., indicated the resident could not speak good "English" and she only spoke a few words in "English."</p> <p>The resident's admission date to the facility was 11/21/13.</p> <p>An "Initial Assessment" dated 1/19/14, indicated "...25. Hearing, Vision and Speech: Resident has the ability to understand and be understood. Family Private Caregiver manages hearing,</p>		<p>review and monitor the careplans/nursing notes and progress notes of each resident seen by the medical director weekly. Weekly review will allow the Director of Nursing to see changes in condition, new orders, and other items that should be reflected in the service plan 5 The item will be corrected by July 5, 2014</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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>vision and speech needs. Details: No service needed...."</p> <p>The resident's "Initial Assessment" lacked documentation that she spoke a foreign language as her preferred language.</p> <p>During an interview on 5/30/14 at 11:50 A.M., the Director of Nursing (DoN) indicated the resident spoke English and she understood "English", but she reverted back to "Swedish", which was her home language. The DoN indicated she should have addressed the resident's communication issues on her Service Plan. She indicated the "Initial Assessment" dated 1/19/14 was the resident's admission Service Plan and she normally had the Admission Service Plan completed right after the resident was admitted to the facility.</p> <p>2. Resident #7's record was reviewed on 5/30/14 at 9:40 A.M. Diagnoses included, but were not limited to, cardiac pacemaker, atrial fibrillation, hypertension, asthma, and hyperlipidemia.</p> <p>A "Nursing Evaluation" dated 5/5/14 indicated the resident had a pacemaker.</p> <p>An "Annual Assessment" dated 5/16/14,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>indicated "...2. Nurse Evaluation: Cardiac: hx [history] benign essential hypertension, atrial fibrillation, pacemaker... 12. Heath Monitoring:...."</p> <p>The "Annual Assessment" lacked information regarding the cardiac pacemaker checks.</p> <p>During an interview on 5/30/14 at 10:30 A.M., the DoN indicated the "Annual Assessment" dated 5/16/14 was the resident's admission Service Plan and the resident's pacemaker checks should have been addressed under the cardiac area of the Service Plan and she failed to do that.</p> <p>3. Resident #6's record was reviewed on 5/28/14 at 1:30 P.M. Diagnoses included, but were not limited to, dementia, diabetes, and a cardiac pacemaker.</p> <p>The resident's service plan was dated 11/25/2013 and was signed by the facility staff (the Director of Nursing) on 1/20/2014, but not signed by the resident's POA (Power of Attorney-- a person allowed to sign for the particular individual that may they are representing).</p> <p>The service plan lacked information regarding the resident's pacemaker. In an interview on 5/30/14 at 11 A.M., the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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			
R000241	<p>DON (Director of Nursing) indicated the service plans should include a note regarding a resident's pacemaker and it should be under cardiac notes. She indicated that the service plan on 11/25/13 did not have any notes or mention of the resident's pacemaker and did not explain on the reason why this was so.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview and record review, the facility failed to administer medications as ordered by the physician and the residents self medicated without an evaluation and orders by the physician for 2 of 5 residents reviewed for self medication administration. (Residents #4 and #11).</p> <p>Findings include:</p> <p>1. On 5/29/14 at 11:10 A.M., Resident #4 was observed self administering a medication using her nebulizer (a machine used for medication breathing treatments). The resident indicated at</p>	R000241	<p>1 The residents involved were assess to determine if they were able to self administer their medication. Both residents expressed a desire to administer their own medication. After determining they were capable of administering there own medicine the Physician was contacted and the issue discussed The physician generated an order for both resident to self administer their own medication 2 All residents have the potential to be affected. Nursing meeting was conducted to determine if any other residents were administering their own medicine and all resident with an order for self medication of medicine were</p>	07/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>this time that she self administers this medication. She indicated the other medications she takes are provided and administered by nursing staff.</p> <p>On 5/29/14 at 3:15 P.M., Resident #4's record was reviewed. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), cognitive impairment and Obstructive sleep apnea.</p> <p>The resident's May 2014, Physician's Order included, but were not limited to, breathing medication: " Ipratropium / sol [solution] Albuter [Albuteral] for: Duoneb inhale 1 vial per nebulizer twice daily...."</p> <p>In an interview on 5/29/14 at 3:45 P.M., the DON (Director of Nursing) indicated nursing assisted this resident with all her medications so she was not sure why she was administering her own medication.</p> <p>Resident #4's service record dated 3/25/2014, indicated the following: "Medication: Inhalers [name of resident] receives nebulizer treatments when needed. Breathing treatments are ordered as needed. Medication: Staff administers routine and PRN [as needed] medication. Medications will be properly taken as prescribed by the physician. nursing</p>		<p>checked and the information was compared to the residents nurses were allowing to self administer their own medicine. 3. Nurse's and QMA's were inserviced on facility policy for self administration of medicine. Assessments will be done on admission to determine if a resident is able to self administer their medicine and when a resident or family member requests self administration of medication to determine who may or may not be able to administer their own medication 4 The Director of Nursing will review all new admissions to determine if they are able to self-administer medication (SAM) and review with care plan review all residents who SAM per the nurses to make sure the medical documentation matches the practice of the nurses 5 This item will be completed by July 5, 2014</p> <p>The facility request an IDR for this deficiency. The facility believes this item did not rise to the level of being an offense because this was not a life threatening issue for either resident. The nursing staff measure out the medicine in the nebulizer and the resident simply held the face mask to her face and has been doing this for years. She was assessed as able to administer her own medicine and she wished to do this on her own.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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			
R000354	<p>administers all resident medications, per physician orders...."</p> <p>In an interview with QMA (Qualified Medication Assistant) #1 on 5/30/14 at 11:10 A.M., she indicated the resident had been administering her own nebulizer treatments.</p> <p>A self medicate assessment or an order that allowed the resident to self medicate was not found in Resident #4's record.</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on interview and record review, the facility failed to ensure transfer information was completely documented for 2 of 5 residents reviewed for transfer</p>	R000354	1. Any additional information, if needed by the receiving facility, was be provided. Nurses were immediately informed to fill out the front and back of the transfer	07/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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>information. (Residents #7 and #9)</p> <p>Findings include:</p> <p>1. Resident #7's record was reviewed on 5/30/14 at 9:40 A.M. Diagnoses included, but were not limited to, dementia, pacemaker, anxiety, depression and atrial fibrillation.</p> <p>A "Resident Transfer Form" indicated the resident had been transferred to (name of facility) on 5/22/14. The form had not indicated the location of the resident's personal property when transferred to the acute care facility. The transfer form had lacked the following information: a nurses notes or copies of attachments to indicate any nurses notes that related to the resident's condition on transfer, functional abilities and physical limitations, nursing care she required prior to transfer, the medications and treatments she had ordered and was administered for that particular day. The form had lacked the date of her last chest X-ray and skin test for tuberculosis.</p> <p>2. Resident #9's record was reviewed on 5/29/14 at 9:40 A.M. Diagnoses included, but were not limited to, multiple myeloma, chronic obstructive pulmonary disease, osteoporosis, and history of renal insufficiency.</p>		<p>form. Nurse's were attaching all the information rather than filling out the back of the form, however, nurse's were instructed to note on the back of the form all attachments or to keep copies of the attachments</p> <p>2. All resident's have the potential to be affected by this issue. Residents currently out of the facility will be checked to make sure the receiving facility has all the information they need for treatment.</p> <p>3. All nursing staff will be inserviced on the appropriate use of a transfer form.</p> <p>4. Director of nursing will monitor in her weekly checks of the charts to make sure the staff are filling out the front and back of the transfer form and noting which records are attached to the form in lieu of filling out the form.</p> <p>5. This item will be completed by July 5, 2014.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/30/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE	STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038
--	---

(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>A "Resident Transfer Form" indicated the resident had been transferred to (name of facility) on 2/27/14. The form had lacked the following information: the location of the resident's personal property when transferred to an acute care facility, vital signs at the time of transfer, a nurses notes that related to the resident's functional abilities and physical limitations, nursing care she received prior to the transfer, the condition of the resident on transfer, medications and treatments she had ordered and was administered for that particular day, and the resident's current diet. The form had lacked the date of her last chest X-ray and skin test for tuberculosis.</p> <p>A "Resident Transfer Form" indicated the resident had been transferred to (name of facility) on 3/17/14. The form had lacked a nurses' note related to the resident's functional abilities and physical limitations, nursing care she received prior to the transfer, medications and treatments she had ordered and was administered for that particular day, and her condition on transfer. The form had lacked the date of her chest X-ray and skin test for tuberculosis.</p> <p>During an interview on 5/29/14 at 3:00 P.M., the Director of Nursing indicated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/30/2014	
NAME OF PROVIDER OR SUPPLIER HEARTH AT WINDERMERE				STREET ADDRESS, CITY, STATE, ZIP CODE 9745 OLYMPIA DR FISHERS, IN 46038			
(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
	the nurses' notes should have noted the receiving facility had received report by telephone. She indicated the "Resident Transfer Form" should have had the required information documented to inform the receiving facility.						