

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
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NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: February 1, 2, 3, 4, 5, & 8, 2016</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Census bed type: SNF: 2 SNF/NF: 69 Residential: 9 Total: 80</p> <p>Census payor type: Medicare: 9 Medicaid: 44 Other: 18 Total: 71</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on February 16, 2016.</p>	F 0000		
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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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F 0221 SS=D Bldg. 00	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to an alarming seat belt not being monitored for 1 of 1 residents reviewed for physical restraints. (Resident #24)</p> <p>Finding includes:</p> <p>On 2/1/16 at 12:08 PM, Resident #24 was observed propelling her wheelchair up and down the hallway of the ACU (Alzheimer's Care Unit). A seat belt was in place around her waist.</p> <p>On 2/3/16 at 11:13 AM, Resident #24 was observed sitting quietly in her wheelchair in the unit activity area with staff feeding her a pudding snack. A seat belt was observed in place around her waist.</p>	F 0221	<p>F221</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state</i></p>	03/04/2016	

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	<p>On 2/3/16 at 11:20 AM, Resident #24 was observed independently wheeling herself up and down the hallway in her wheelchair with her seat belt in place.</p> <p>On 2/4/16 at 11:38 AM, Resident #24 was observed wheeling herself independently in her wheelchair in the hallway with her seatbelt in place.</p> <p>Resident #24's record was reviewed on 2/3/16 at 2:27 PM. Diagnoses included, but were not limited to, cognitive communication deficit, muscle weakness, gait abnormality, dementia without behaviors, major depressive disorder and bipolar disorder.</p> <p>A quarterly MDS (Minimum Data Set) assessment dated 11/21/15 indicated the resident was severely cognitively impaired. The MDS lacked indication a restraint was in use for Resident #24.</p> <p>A Physician's Order dated 9/3/15 indicated alarming seatbelt to wheelchair.</p> <p>A Restraint Consent was signed by the POA (Power of Attorney) on 9/1/15 and a Restraint Evaluation/ review was completed on 9/2/15 for the alarming seatbelt to the wheelchair.</p>		<p><i>law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #24 was assessed with no negative findings related to restraint use. Restraint documentation was reviewed for Resident #24.</p> <p>2) How the facility identified other residents:</p> <p>No other residents have a physical restraint at this time.</p> <p>3) Measures put into place/ System changes:</p> <p>Nursing staff will be re-educated regarding appropriate documentation of restraints, including specific times the restraint is in use, when it was checked and when it was released.</p>	

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	<p>A quarterly Restraint Evaluation/ review was completed on 12/2/15.</p> <p>Review of the current CNA task list included: "alarming seatbelt to wheelchair - check every hour, release every 2 hours."</p> <p>Review of the CNA charting since 9/2/15 did not indicate which specific times of day the seatbelt restraint was in use for the resident, when it was being monitored, or when it was being released.</p> <p>Review of Resident #24's care plans lacked a care plan for restraints. The fall risk care plan indicated an alarming self releasing seatbelt to the wheelchair as an intervention.</p> <p>Interview with CNA #2 on 2/4/16 at 11:19 a.m., indicated Resident #24 had been taking apart her seatbelt all morning but was unable to do so on command due to her dementia.</p> <p>Interview with the DON on 2/5/16 at 10:00 AM, indicated the current CNA restraint charting did not indicate when the resident was observed to be in the restraint or that staff observed her hourly while in the restraint. She further indicated the charting method needed to be evaluated, inserviced and changed to</p>		<p>Electronic documentation of restraint use has been modified to include separate documentation tasks for restraint being checked and restraint being released.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or designee will audit restraint documentation at least 3 times per week to ensure compliance.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 3-4-16</p>		

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F 0278 SS=D Bldg. 00	<p>correctly reflect the restraint use and monitoring by staff.</p> <p>A policy titled "Use of Restraints" was provided by the DON on 2/5/16 at 9:20 AM and deemed as current. The policy indicated, " 8. The need for restraint will be re-evaluated monthly for the first three months, then quarterly to determine if continued restraint is necessary...."</p> <p>There was no guidance involving the daily monitoring and release of the restraint.</p> <p>3.1-26(d) 3.1-26(f) 3.1-26(g) 3.1-26(h)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>				

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	<p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to accurately document dialysis and restraints on the MDS (Minimum Data Set) assessments for 1 of 1 of residents reviewed for dialysis and 1 of 1 residents reviewed for restraints. (Residents #49 and #24)</p> <p>Findings include:</p> <p>1. The record for Resident #49 was reviewed on 2/4/16 at 11:30 a.m. The resident was readmitted to the facility on 8/5/15. The resident's diagnoses included, were not limited to, chronic kidney disease and diabetes mellitus.</p>	F 0278	<p>F278</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required</i></p>	03/04/2016	

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	<p>Review of the current Physician Order Sheet for January and February 2016 indicated the dialysis permacath (access site for dialysis) was assessed every shift for signs and symptoms of bleeding.</p> <p>Review of the Physician's Orders indicated on 9/2/15, the resident was to have dialysis every Tuesday, Thursday and Saturday at the dialysis center (name of dialysis center).</p> <p>Review of the resident's Quarterly Minimum Data Set (MDS) assessments dated 9/3/15 and 12/5/15 lacked an indication of dialysis.</p> <p>Interview with the Minimum Data Set Coordinator on 2/4/16 at 2:32 p.m., indicate dialysis should have been documented on both of the Quarterly MDS's.</p> <p>2. On 2/1/16 at 12:08 PM, Resident #24 was observed propelling her wheelchair up and down the hallway of the ACU (Alzheimer's Care Unit). A seat belt was in place around her waist.</p> <p>On 2/3/16 at 11:13 AM, Resident #24 was observed sitting quietly in her wheelchair in the unit activity area with staff feeding her a pudding snack. A seat belt was observed in place around her waist.</p>		<p><i>by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #49 and #24- Modification of MDS has been completed</p> <p>2) How the facility identified other residents:</p> <p>MDS completed on residents receiving dialysis were reviewed to ensure documentation was completed accurately. No other residents were identified.</p> <p>No other residents currently have a restraint.</p> <p>Most recent MDS completed in the last 30 days will be reviewed to ensure accurate documentation was completed. If any deficiencies are noted, a MDS modification will be submitted as indicated.</p>		

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	<p>Resident #24's record was reviewed on 2/3/16 at 2:27 PM. Diagnoses included, but were not limited to, cognitive communication deficit, muscle weakness, gait abnormality, dementia without behaviors, major depressive disorder and bipolar disorder.</p> <p>A Physician's Order dated 9/3/15 indicated alarming seatbelt to wheelchair.</p> <p>A Restraint Consent was signed by the POA (Power of Attorney) on 9/1/15 and a Restraint Evaluation/ review was completed on 9/2/15 for the alarming seatbelt to the wheelchair.</p> <p>A quarterly MDS (Minimum Data Set) assessment dated 11/21/15 indicated the resident was severely cognitively impaired. The MDS lacked indication a restraint was in use.</p> <p>Interview with the MDS Coordinator on 2/4/16 at 2:38 PM, indicated the November MDS should have had a restraint marked as being used for Resident #24.</p> <p>3.1-31(d)(3) 3.1-31(e)</p>				<p>3) Measures put into place/ System changes:</p> <p>The Director of Nursing or designee will audit at least 3 MDS per week completed in the prior 7 days to ensure accurate documentation prior to submission. If any deficiencies are noted, corrections will be made prior to submission.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 3-4-16</p>		

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F 0279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a resident had a comprehensive care plan related to dialysis for 1 of 1 residents reviewed for dialysis. (Resident #49)</p> <p>Finding includes:</p> <p>The record for Resident #49 was reviewed on 2/4/16 at 11:30 a.m. The resident was readmitted to the facility on 8/5/15. The resident's diagnoses</p>	F 0279	<p>F279 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of</p>	03/04/2016
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F 0280 SS=D Bldg. 00	<p>included, were not limited to, chronic kidney disease and diabetes mellitus.</p> <p>Review of the residents care plans, lacked an indication of care plan for dialysis. Orders:</p> <p>Interview with the Director of Nursing on 2/4/16 at 2:26 p.m., indicated there should have been a care plan for dialysis.</p> <p>Interview with the Minimum Data Set Coordinator on 2/4/16 at 2:32 p.m., indicated there should have been a care plan for dialysis.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged</p>		<p><i>federal and state law.</i> 1) Immediate actions taken for those residents identified: Resident #49- Dialysis care plan was completed. 2) How the facility identified other residents: All residents receiving dialysis were reviewed to ensure care plan for dialysis was in place. No other residents were affected. All resident care plans will be reviewed in the next 30 days to ensure that appropriate care plans are in place as indicated. Any deficiencies will be corrected. 3) Measures put into place/ System changes: The MDS Coordinator or designee will audit all resident care plans in the next 30 days to ensure appropriate care plans are in place as indicated, with corrections made as indicated. A minimum of 3 resident care plans will be reviewed thereafter weekly within 7 days after completion of MDS to ensure care plans are complete and accurate. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 3-4-16</p>		

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	<p>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure each resident had an accurately updated plan of care related to the collaboration of services with Hospice care and monitoring a seat belt restraint for 1 of 26 residents whose record was reviewed. (Resident #24)</p> <p>Findings include:</p> <p>1. On 2/1/16 at 12:08 PM, Resident #24 was observed propelling her wheelchair up and down the hallway of the ACU (Alzheimer's Care Unit). A seat belt was in place around her waist.</p> <p>On 2/3/16 at 11:13 AM, Resident #24 was observed sitting quietly in her wheelchair in the unit activity area with</p>	F 0280	<p>F280 The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i></p> <p>Immediate actions taken for those residents identified: Resident #24- Hospice care plan was revised to include coordination of care and services with Hospice provider. Updated care plans were requested and received from Hospice provider and placed in Hospice binder.</p>	03/04/2016			

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	<p>staff feeding her a pudding snack. A seat belt was observed in place around her waist.</p> <p>Resident #24's record was reviewed on 2/3/16 at 2:27 PM. Diagnoses included, but were not limited to, cognitive communication deficit, muscle weakness, gait abnormality, dementia without behaviors, major depressive disorder and bipolar disorder.</p> <p>A quarterly MDS (Minimum Data Set) assessment dated 11/21/15 indicated the resident was severely cognitively impaired and received special services - hospice care. The MDS lacked indication a restraint was in use.</p> <p>Review of Resident #24's Hospice communication binder kept at the Nurses' station indicated the last Hospice staff visit note was dated 12/24/15 and the last Physician orders and plan of care on file was dated through 11/11/15.</p> <p>Review of facility care plans indicated the following: - "Hospice care d/t (due to) terminal illness. Interventions: no invasive procedures; medication as ordered; O2 (oxygen) as ordered; soothing music therapy; supportive, private environment for resident & family." The care plan</p>		<p>Care plan for restraint use was added. 2) How the facility identified other residents: Residents receiving Hospice services were reviewed to ensure care plan was in place for Hospice services and coordination of care, as well as current plan of care present in Hospice binder. No other residents currently have a restraint. All resident care plans will be reviewed in the next 30 days to ensure that appropriate care plans are in place as indicated. Any deficiencies will be corrected. 3) Measures put into place/ System changes: The Social Service Director will review Hospice binders weekly to ensure current care plans are present. All residents with a restraint will be reviewed monthly x30 days, then quarterly thereafter to ensure care plan for restraint use is in place and accurate. The MDS Coordinator or designee will audit all resident care plans in the next 30 days to ensure appropriate care plans are in place as indicated, with corrections made as indicated. A minimum of 3 resident care plans will be reviewed thereafter weekly within 7 days after completion of MDS to ensure care plans are complete and accurate. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until</p>				

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	<p>lacked coordination of services with Hospice staff. A Physician's Order dated 9/3/15 indicated alarming seatbelt to wheelchair.</p> <p>A Restraint Consent was signed by the POA (Power of Attorney) on 9/1/15 and a Restraint Evaluation/ review was completed on 9/2/15 for the alarming seatbelt to the wheelchair.</p> <p>A quarterly Restraint Evaluation/ review was completed on 12/2/15.</p> <p>Review of the current CNA task list included: "alarming seatbelt to wheelchair - check every hour, release every 2 hours."</p> <p>Review of Resident #24's care plans lacked a care plan for restraints. The fall risk care plan indicated an alarming self releasing seatbelt to the wheelchair as an intervention.</p> <p>Interview with the ADON on 2/3/16 at 11:24 AM, indicated facility staff had verbal communication with the Hospice staff during visits and also had a Hospice communication binder at the Nurses' station for each resident.</p> <p>Follow up interview with the ADON on 2/4/16 at 9:38 AM, indicated the Hospice</p>		100% compliance is achieved x3 consecutive months. 5) Date of compliance: 3-4-16		

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	<p>center stated the Hospice nurses were supposed to bring the visit notes with them to the facility and place them in each resident's binder to keep it updated. She further indicated she had asked Hospice to fax all missing notes.</p> <p>Interview with the ADON on 2/4/16 at 11:45 AM, indicated both nursing and the MDS coordinator were responsible for updating resident care plans.</p> <p>Interview with the DON on 2/5/16 at 9:30 AM, indicated staff should be able to access up to date information in each resident's hospice binder to know what is current and the expectation is for Hospice staff to keep binder updated.</p> <p>Interview on 2/5/16 at 1:44 PM with Hospice Nurse #1, indicated she was made aware the Hospice binder for Resident #24 was not updated and she would be bringing all of the missing notes and recent Physician orders and plan of care.</p> <p>3.1-35(a) 3.1-35(b) 3.1-35(f)</p>			

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F 0282 SS=D Bldg. 00	<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 observation, record review, and interview, the facility failed to ensure a care plan was followed as written related to skin discolorations not assessed and monitored for 1 of 3 resident's reviewed for skin (non-pressure related), of the 4 who met the criteria for skin (non-pressure related). (Resident #41)</p> <p>Finding includes:</p> <p>On 2/2/16 at 10:33 a.m., Resident #41 was observed sitting up in her bed. The resident was observed to have a red/purple discoloration to the top of both hands. At the time of the observation the resident indicated she had probably bumped her hands on something.</p> <p>On 2/4/16 at 9:25 a.m., Resident #41 was observed lying in bed with a red/purple discoloration to the top of both hands.</p> <p>Record review for Resident #41 was completed on 2/2/16 at 2:42 p.m. The resident's diagnoses included, but were not limited to, heart failure, hypertension, and atrial fibrillation.</p>	F 0282	<p>F 282</p> <p>The facility requests paper compliance for this citation:</p> <p>This Plan of Correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Resident # 41 was assessed for any further bruising or injury with no negative findings. Plan of care reviewed and updated.</p> <p>2) How the facility identified other residents :</p>	03/04/2016	

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	<p>A care plan indicated: The resident was on anticoagulant therapy (blood thinning medication) related to atrial fibrillation. The interventions included to monitor/document/report when necessary any adverse reactions of the anticoagulant therapy which included bruising.</p> <p>A Nursing Noted dated 1/30/16 at 7:39 p.m., indicated a weekly skin observation had been completed with no skin concerns observed.</p> <p>Nursing Notes reviewed from 1/30/16 through 2/3/16 indicated no observations of the discolorations had been observed.</p> <p>Interview with LPN #2 on 2/4/16 at 9:30 a.m., indicated she was unaware if the resident had any discolorations to her hands and would have to find out.</p> <p>Interview with LPN #3 on 2/4/16 at 9:35 a.m., indicated she was unaware if the resident had any discolorations to her hands and she would have to check.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/5/16 at 10:20 a.m., indicated she was unaware of the discolorations observed on the resident's hands until it was brought to her attention yesterday. She further indicated since the</p>		<p>Skin sweep performed on all residents to ensure there are no undocumented bruises or skin issues.</p> <p>3) Measures put into place / Systemic changes :</p> <p>Nursing staff will be re-educated regarding policy & procedure for skin inspection, reporting and documentation of skin conditions.</p> <p>Nursing staff will be re-educated regarding providing care according to the care plan.</p> <p>4) How the corrective actions will be monitored :</p> <p>The Director of Nursing or designee will assess 5 residents per week and review documentation to ensure all skin conditions are identified, documented appropriately and care provided according to plan of care . Any deficiencies noted will be corrected and addressed with re-education of staff and/or disciplinary action as deemed appropriate.</p>	

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F 0309 SS=D Bldg. 00	<p>resident was on a blood thinning medication the staff should have been observing the resident's skin on a daily basis.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 2 of 3 residents reviewed for non pressure related skin conditions of the 4 residents who met the criteria for non pressure related skin conditions. (Resident #41 and #61)</p> <p>Findings include:</p>	F 0309	<p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months</p> <p>or until 100% compliance is achieved times three consecutive months.</p> <p>5) Date of compliance : 3/4/2016</p> <p>F 309</p> <p>The facility requests paper compliance for this citation.</p> <p>This Plan of Correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies .</p>	03/04/2016	

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	<p>1. On 2/2/16 at 10:33 a.m., Resident #41 was observed sitting up in her bed. The resident was observed to have a red/purple discoloration to the top of both hands. At the time of the observation the resident indicated she had probably bumped her hands on something.</p> <p>On 2/4/16 at 9:25 a.m., Resident #41 was observed lying in bed with a red/purple discoloration to the top of both hands.</p> <p>Record review for Resident #41 was completed on 2/2/16 at 2:42 p.m. The resident's diagnoses included, but were not limited to, heart failure, hypertension, and atrial fibrillation.</p> <p>The Quarterly Minimum Data Set (MDS) assessment completed on 10/31/15 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 10 which indicated the resident was cognitively moderately impaired. The assessment indicated the resident had received an anticoagulant medication (blood thinning medication).</p> <p>A Physician's Order dated 1/11/16 indicated the resident received Coumadin (blood thinning medication) 3 mg (milligrams) daily for atrial fibrillation.</p> <p>A care plan indicated: The resident is on</p>		<p>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Resident # 41 and #61 were assessed for any further bruising or injury with no negative findings. Plan of care reviewed and updated.</p> <p>2) How the facility identified other residents :</p> <p>Skin sweep performed on all residents to ensure there are no undocumented bruises or skin issues.</p> <p>3) Measures put into place / Systemic changes :</p> <p>Nursing staff will be re-educated regarding Skin Inspection & Reporting.</p> <p>4) How the corrective actions will be monitored :</p> <p>The Director of Nursing or designee</p>	

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	<p>anticoagulant therapy (blood thinning medication) related to atrial fibrillation. The interventions included to monitor/document/report when necessary any adverse reactions of the anticoagulant therapy which included bruising.</p> <p>A Nursing Noted dated 1/30/16 at 7:39 p.m., indicated a weekly skin observation had been completed with no skin concerns observed.</p> <p>Nursing Notes reviewed from 1/30/16 through 2/3/16 indicated no observations of the discolorations had been observed.</p> <p>Interview with LPN #2 on 2/4/16 at 9:30 a.m., indicated she was unaware if the resident had any discolorations to her hands and would have to find out.</p> <p>Interview with LPN #3 on 2/4/16 at 9:35 a.m., indicated she was unaware if the resident had any discolorations to her hands and she would have to check.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 2/5/16 at 10:20 a.m., indicated she was unaware of the discolorations observed on the resident's hands until it was brought to her attention yesterday. She further indicated since the resident was on a blood thinning medication the staff should have been</p>		<p>will assess 5 residents per week and review documentation to ensure skin conditions are identified and documented appropriately.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months</p> <p>or until 100% compliance is achieved times three consecutive months.</p> <p>5) Date of compliance : 3/4/2016</p>				

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	<p>observing the resident's skin on a daily basis.</p> <p>2. On 2/2/15 at 11:43 AM, Resident #61 was observed to have a quarter-sized dark purple discoloration to the top of his hand between his thumb and index finger.</p> <p>On 2/3/16 at 10:14 AM, Resident #61 was observed sitting on the side of the bed. A quarter-sized dark discoloration remained to the top of his right hand He indicated it had been there a couple days and thought he had probably bumped it on something.</p> <p>On 2/4/16 at 2:51 PM, Resident #61 was observed sitting in bed. No change was observed to the discoloration to his right hand.</p> <p>On 2/5/16 at 10:40 AM the ADON/ Wound Nurse observed the discolored area to Resident #61's right hand. She indicated she was unaware previously of any skin issues for the resident. She further indicated staff should be looking at residents' skin daily during interaction, even if they do not need ADL (Activities of Daily Living) assistance and the CNA's should report any possible issues to the nurse to assess.</p> <p>Interview with CNA #1 on 2/3/16 at</p>			

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	<p>10:19 AM, indicated Resident #61 had showers offered every M/W/F and did need assist, but had not had a shower yet that morning. She further indicated CNA's definitely do skin checks with showers and also should do when cueing him daily with dressing, though he does not require physical assist for dressing. She was unaware of any current skin issues for Resident #61.</p> <p>Resident #61's record was reviewed on 2/3/16 at 10:04 AM. Diagnoses included, but were not limited to, cognitive communication deficit, vitamin B deficiency, nonthrombocytopenic purpura, hypertension, tachycardia, COPD, dementia without behaviors, and osteoporosis.</p> <p>A quarterly MDS (Minimum Data Set) assessment dated 12/12/15 indicated the resident was cognitively intact.</p> <p>A weekly skin assessment dated 1/29/16 indicated no skin issues.</p> <p>Review of Progress notes since 1/29/16 lacked indication of any discoloration to Resident #61's right hand.</p> <p>A policy titled "Pressure Ulcer and Skin Assessment Policy" was presented by the DON on 2/5/16 at 1:30 PM and deemed</p>			

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F 0328 SS=D Bldg. 00	<p>as current. The policy indicated, " Standards: ... 4. Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment ... 19. The resident's care plan will be revised as appropriate, to reflect alteration of skin integrity, approaches and goals for care"</p> <p>3.1-37(a)</p> <p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review, facility staff failed to remain with a cognitively impaired resident during a breathing treatment for 1 of 1 residents observed for breathing</p>	F 0328	<p>F 328</p> <p>This facility requests paper</p>	03/04/2016			

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	<p>treatment administration of the 15 residents observed during medication pass observations. (Resident #44)</p> <p>Finding includes:</p> <p>During a Medication Administration Observation on 2/4/16 at 11:44 AM on the ACU (Alzheimer's Care Unit), LPN #4 assessed Resident #44's lungs, checked her oxygen level, and started an Albuterol (medication used to help breathing) nebulizer treatment via mask. She spoke with the resident and her husband, said she would be back, and left the room, at which time she proceeded to pass medications to other residents on the unit.</p> <p>On 2/4/16 at 12:00 PM, LPN #4 returned to Resident #44's room, removed the treatment mask, rechecked the resident's oxygen level and lungs, rinsed the mask with water and left it out to dry.</p> <p>Interview with LPN #4 on 2/4/2016 at 12:10 PM, indicated Resident #44's husband was almost always in the room and monitored his wife with her breathing treatment, otherwise she would stay with the resident throughout the treatment.</p> <p>Interview with the DON on 2/4/16 at</p>		<p>compliance for this citation:</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider. Of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Resident # 44 was assessed with no negative findings.</p> <p>2) How the facility identified other residents :</p> <p>An audit was completed to identify all other residents who received nebulizer treatments.</p> <p>3) Measures put into place / Systemic changes :</p> <p>Nurses will be re-educated regarding Nebulizer / Breathing Treatment Administration to ensure nebulizer policy is followed.</p> <p>4) How the corrective actions will be monitored :</p>		

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	<p>12:20 PM, indicated the nurses were supposed to remain in the room with any resident throughout the entire respiratory treatment.</p> <p>Resident #44's record was reviewed on 2/5/16 at 3:08 PM. Diagnoses included, but were not limited to, dementia without behaviors, acute upper respiratory infection, altered mental status, and cognitive communication deficit.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 12/10/15 indicated the resident was moderately cognitively impaired.</p> <p>Review of care plans included the following: "Resident presents with cognitive loss aeb (as evidenced by) BIMS (Brief Interview of Mental Status) score of 9 indicating moderate impairment."</p> <p>A policy titled "Nebulizer Therapy" was presented by the DON on 2/4/16 at 12:20 PM and deemed as current. The policy indicated, " Procedure: ... 2. When delivering the treatment, stay with the resident until the procedure has been completed, unless the resident has completed a self-administration of medications indicating that they are capable to monitor their progress during</p>		<p>The Director of Nursing and/ or designee will observe nebulizer administration at least 3 times per week on varied shifts x30 days, then twice weekly on varied shifts thereafter to ensure compliance.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 consecutive months.</p> <p>5) Date of compliance : 3/4/2016</p>	

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F 0334 SS=D Bldg. 00	<p>treatment"</p> <p>3.1-47(a)(6)</p> <p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p>				

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	<p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>Based on record review and interview the facility failed to offer the influenza vaccine to residents annually and administer the vaccine timely for 3 of 5 residents reviewed for influenza and pneumococcal vaccines. (Resident #4,</p>	F 0334	F 334 This facility requests paper compliance for this citation: This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute	03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155572		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/08/2016	
NAME OF PROVIDER OR SUPPLIER APERION CARE DEMOTTE				STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310			
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	<p>#68, and #31)</p> <p>Finding includes:</p> <p>1. Interview with the Director of Nursing (DON) on 2/8/16 at 12:30 p.m. indicated some residents had signed an original influenza vaccine consent which gave consent to administer the vaccine annually. The DON provided the following influenza vaccine consent forms:</p> <p>a. Resident #4's most recent influenza vaccine consent was dated 10/12/12 and indicated she had refused the immunization. Review of the resident's record on 2/8/16 at 1:00 p.m. lacked documentation the resident was offered the influenza vaccine annually.</p> <p>b. Resident #68's most recent influenza vaccine consent was dated 2/9/15 and indicated he wished to have the vaccine administered once between October 1 and March 31. Review of the resident's record on 2/8/16 at 1:00 p.m. indicated he had last received the influenza vaccine on 12/29/14.</p> <p>c. Resident #31's most recent influenza vaccine consent was dated 9/5/13 and indicated he wished to have the vaccine administered annually in the fall. Review</p>		<p>admission or agreement by the provider. Of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified : Resident # 4, # 31 & #68 were offered influenza vaccine and administered as requested. 2) How the facility identified other residents: An audit was completed of influenza and pneumococcal vaccine consents and documentation on all residents. All residents who consented to vaccine but did not receive will be re-offered vaccine. 3) Measures put into place / Systemic changes: Nurses will be re-educated regarding policy for obtaining consent, required education and administration of Influenza and Pneumococcal vaccines. . 4) How the corrective actions will be monitored: The Director of Nursing or designee will audit new admissions to ensure appropriate consent was obtained, vaccine ordered and given in a timely manner within 7 days from consent or admission. The Director of Nursing or designee will audit influenza consents and administration on a weekly basis during flu season October 1st through March 31st until all residents in the facility</p>				

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F 0431 SS=D Bldg. 00	<p>of the resident's record on 2/8/16 at 1:00 p.m. indicated he had last received the influenza vaccine on 10/31/14.</p> <p>Interview with the DON on 2/8/16 at 1:06 p.m. indicated Resident #31 had not yet received the influenza vaccine this season. She indicated she was unsure if Resident #68's consent was from last flu season or the current one and was unsure if he was offered the vaccine this season. She further indicated she could not find any other documentation Resident #4 had been offered the influenza vaccine annually.</p> <p>A facility policy titled "Policy for Influenza Vaccination of Residents", undated, and received as current from the Administrator, indicated, "...It is the policy of this facility that annually, in the fall, residents will be offered immunization against influenza..."</p> <p>3.1-13(a)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in</p>				<p>have received vaccinations and/or have been offered vaccines and received vaccine education materials. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 consecutive months.</p> <p>5) Date of compliance : 3/4/2016</p>		

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	<p>sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to ensure proper medication labeling for 5 of 30 medications given to 2 of 15 residents observed during the Medication Administration Observation. (Residents #31 and #25)</p> <p>Findings include:</p>	F 0431	<p>F 431</p> <p>This facility requests paper compliance for this citation:</p> <p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement</p>	03/04/2016	

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	<p>1. During a Medication Administration Observation with LPN #1 on Thursday, 2/4/16 at 3:35 PM, a medication card label for Resident #31 indicated the order, "Coumadin 5 mg (milligrams) PO (by mouth) q (every) M/W/F (Monday/ Wednesday/ Friday). LPN #1 rechecked the current eMAR (electronic Medication Administration Record) order in her computer and indicated the order had been changed to "Coumadin 5 mg po daily" on 1/11/16. She further indicated an order change sticker should have been placed on the medication card at the time of the order change.</p> <p>Review of Resident #31's record on 2/5/16 at 8:30 AM indicated a Physician's Order for Coumadin 5 mg po daily.</p> <p>2. During a Medication Administration Observation with LPN #1 on 2/4/16 at 3:55 PM, the medication card labels for Resident #25 indicated the following orders:</p> <ul style="list-style-type: none"> - hydrocortisone 20 mg via peg (feeding) tube bid (twice daily) - glipizide 5 mg - give 1 1/2 tab (7.5 mg) via peg tube bid - gabapentin 300 mg via peg tube bid - famotadine 20 mg via peg tube bid <p>LPN #1 indicated Resident #25 now received all of his medications by mouth</p>		<p>by the provider. Of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Medication labels for Resident # 31 & # 25 were update and pharmacy notified of changes.</p> <p>2) How the facility identified other residents :</p> <p>A medication audit will be performed by pharmacy on all current residents to ensure proper medication storage, labeling and expiration dates.</p> <p>3) Measures put into place / Systemic changes :</p> <p>Nurses will be re-educated regarding Medication Storage, Labeling and Expiration Dates, including use of direction change sticker when orders are changed.</p> <p>4) How the corrective actions will be monitored :</p> <p>The Director of Nursing and or designee will audit medication</p>	

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	<p>crushed in applesauce and only a saline flush was administered into his peg tube, but she was unsure when this had changed. She further indicated an order change sticker should have been placed on all of the medication cards at the time of the order change.</p> <p>Interview with the ADON on 2/5/16 at 2:40 PM indicated the change from feeding tube medications to oral medications for Resident #25 occurred on 11/24/15.</p> <p>Interview with the DON on 2/5/16 at 9:15 AM indicated an order change sticker should be placed on all medication cards with any medication change in direction at the time of the change.</p> <p>A policy titled Medication Administration, Label Direction Changes was presented by the DON on 2/5/16 at 9:20 AM and deemed as current. The policy indicated, "1. When the directions change on a medication, the pharmacy will not send a new label. Rather, the nurse receiving the directions change order should affix a 'Directions Changed - Refer to Chart' sticker to the bottom right hand corner of existing label"</p> <p>3.1-25(j)</p>		<p>supply on 5 resident per week to ensure medication orders and label are accurate and match.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100 % compliance is achieved times 3 consecutive months.</p> <p>5) Date of compliance : 3/4/2016</p>				

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R 0000 Bldg. 00	3.1-25(k)(5) This visit was for a State Residential Licensure Survey. Residential Census: 9 Residential Sample: 7 The following State Residential findings cited is in accordance with 410 IAC 16.2-5.	R 0000		
R 0035 Bldg. 00	410 IAC 16.2-5-1.2(j)(1-7) Residents' Rights - Deficiency (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose			

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	<p>the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals.</p> <p>(3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement.</p> <p>(4) Refuse any treatment or service, including medication.</p> <p>(5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility.</p> <p>(6) Be afforded confidentiality of treatment.</p> <p>(7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities.</p> <p>Based on record review and interview, the facility failed to ensure a resident or their responsibly party participated in the development of a service plan for 1 of 7 residents records reviewed. (Resident #7)</p> <p>Finding includes:</p> <p>The closed record for Resident #7 was reviewed on 2/8/16 at 9:20 a.m. The resident's diagnoses included, but were</p>	R 0035	<p>R 035</p> <p>The facility requests paper compliance for this citation.</p> <p>This Plan of Correction is the center's credible allegations of compliance.</p> <p>Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth</p>	03/04/2016	

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	<p>not limited to, diabetes mellitus and dementia. The resident was admitted to the facility on 5/11/15.</p> <p>Review of the residents service plan lacked an indication of a signature and a date from the resident or the residents responsible party.</p> <p>Interview with Director of Nursing on 2/8/16 at 1:08 p.m., indicated the service plan was not signed by the resident's responsible party.</p>		<p>I the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Service plan for resident #7 was reviewed. Resident #7 no longer resides in residential care.</p> <p>2) How the facility identified other residents :</p> <p>All current resident's service plans were reviewed for resident /responsible party signature. No other residents were affected.</p> <p>3) Measures put into place / System changes :</p> <p>Social Service Director was re-educated regarding the involvement of resident/family in the development of a Service Plan and obtaining resident/responsible party signature on Service Plan at least every 6 months with semi-annual reviews thereafter.</p> <p>4) How the corrective action will be monitored :</p> <p>The Social Service Director will audit Service Plans on all residents monthly x3 months, then quarterly thereafter to ensure resident and</p>	

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R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (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: (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		responsible party signatures were obtained as required with initial service plan development and with semi-annual reviews. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times three consecutive months. 5) Date of compliance : 3/4/16	

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	<p>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 invite the local fire department to participate in conducting a fire drill at least every 6 months.</p> <p>Finding includes:</p> <p>The fire drill records were reviewed on 2/6/16 at 1:00 p.m. The records lacked documentation to indicate the local fire department attended or was invited to any fire drills conducted from April 2015 through January 2016.</p> <p>During an interview with the Maintenance Supervisor on 2/6/16 at 1:34 p.m., he indicated had not invited the local fire department to conduct a fire drill in September of 2015.</p>	R 0092	<p>R - 092</p> <p>The facility requests paper compliance for this citation.</p> <p>This Plan of Correction is the facilities credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those resident's identified :</p> <p>Fire Marshall was contacted and appointment made to attend a facility fire drill. Fire drill was</p>	03/04/2016

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			<p>completed on 2/25/16 with Fire Marshall.</p> <p>2) How the facility identified other residents :</p> <p>Residents who reside in the assisted living were not affected.</p> <p>3) Measures put into place / System changes :</p> <p>Maintenance Director re-educated regarding inviting Local Fire Department every six months to attend fire/ disaster drill and proper documentation.</p> <p>4) How the corrective actions will be monitored :</p> <p>The HFA or designee will audit Fire Drill Logs monthly to ensure compliance.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved for 3 consecutive months.</p> <p>5) Date of compliance :</p>	

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R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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 record review and interview, the facility failed to ensure physician's orders were clarified and completed related to laboratory tests for 2 of 7 residents reviewed for physicians' orders in a total sample of 7. (Resident #5 and #6)</p> <p>Findings include:</p> <p>1. Record review for Resident #5 was completed on 2/8/16 at 10:50 a.m. The resident's diagnoses included, but were not limited to end stage renal disease, hypertension, and hyperlipidemia.</p>	R 0241	<p>3/4/2016</p> <p>R 241</p> <p>The facility requests paper compliance for this citation.</p> <p>This Plan of Correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the acts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is</p>	03/04/2016

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	<p>A Physician's Order dated 9/3/15 indicated the resident was to have a Lipid Panel (laboratory test for cholesterol levels) and ALT (alanine aminotransferase test) (laboratory test for liver injury) laboratory test completed in January.</p> <p>Review of the resident's completed labs for 1/1/16 through 2/8/16 lacked any indication the laboratory tests had been completed as ordered.</p> <p>Interview with the Director of Nursing (DON) on 2/8/16 at 3:40 p.m., indicated the Lipid Panel and ALT laboratory tests for the resident had been missed and were not completed as ordered.2. The record for Resident #6 was reviewed on 2/8/16 at 12:30 p.m. The resident's diagnoses included, but were not limited to, osteoarthritis, hypertension, and depressive disorder.</p> <p>Review of the 2/2016 Physician Order Summary indicated the following laboratory orders: -fasting lipid panel (a laboratory test for cholesterol) every 12 months, originally ordered 10/2/13 -"corp" annually, originally ordered 1/20/15 Review of the lab results indicated the</p>		<p>required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Lab orders were clarified and labs obtained for resident # 5 and #6.</p> <p>2) How the facility identified other residents :</p> <p>An audit will be completed on all other residents receiving laboratory services to ensure labs were obtained as ordered.</p> <p>3) Measures put into place / Systemic changes :</p> <p>Licensed staff will be re-educated regarding procedure for obtaining lab orders and communication of orders to lab.</p> <p>4) How the corrective actions will be monitored :</p> <p>The Director of Nursing and /or designee will audit lab orders on all residents 3x/week x30 days, then weekly thereafter to ensure labs were drawn as ordered.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100 % compliance is achieved times 3 consecutive months.</p>				

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R 0349 Bldg. 00	<p>fasting lipid panel had not been completed in 2015 as ordered by the Physician.</p> <p>Interview with the Medical Records Nurse on 2/8/16 at 2:30 p.m. indicated she was unsure what type of lab test a "corp" was.</p> <p>Interview with Nurse Practitioner #1 on 2/8/16 at 2:46 p.m. indicated she had never heard of a "corp" lab test before and it was probably a typing error for a CRP (C-reactive protein, a lab test for inflammation).</p> <p>Interview with the Director of Nursing (DON) on 2/8/16 at 3:37 p.m. indicated the lab order had been clarified with the resident's physician and the "corp" test was supposed to be CRP. She further indicated the fasting lipid panel had not been completed as ordered.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p>		5) Date of compliance : 3/4/16				

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	<p>Based on record review and interview, the facility failed to maintain complete and accurately documented records related to missing Physician's Orders, visit notes, and plan of care pertaining to the collaboration of services for wound care and specialized equipment with Home Health for 1 of 7 residents whose records were reviewed. (Residents #4)</p> <p>Findings include:</p> <p>Resident #4's record was reviewed on 2/8/15 at 9:30 AM. Diagnoses included, but were not limited to, anxiety, right AKA (above the knee amputation), hypothyroidism, and osteoporosis.</p> <p>The facility identified Resident #4 was receiving Home Health services on 2/2/15.</p> <p>Review of current Physician Orders listed in the computer for Resident #4 did not include an order for Home Health services.</p> <p>Review of miscellaneous notes indicated sporadic Home Health visit notes had been uploaded, the most recent dated 12/24/15. There were no recent Physician Orders or Plans of care on file.</p>	R 0349	<p>R 349</p> <p>The facility requests paper compliance for this citation.</p> <p>This Plan of Correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Resident # 4- Order for home health services was added to record, service plan updated and home health service was contacted to obtain all current documentation of weekly visits, status of knee brace and wound care.</p> <p>2) How the facility identified other residents :</p> <p>No other residents are receiving home health services.</p>	03/04/2016

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	<p>Review of Resident #4's service plan indicated: "Wounds - receives wound care and treatment by home health; seen by Wound clinic."</p> <p>Interview with the DON on 2/8/15 at 11:45 AM indicated Resident #4 was currently receiving Home Health services weekly but was unsure if she was still being treated for wounds. She also indicated the resident was waiting for a knee brace, which she believed Home Health was also handling since Resident #4 did not see the facility Therapy department. She further indicated Home Health should be bringing updated notes for their visits for the facility staff to have available in the resident's computerized record.</p> <p>Interview with Medical Records on 2/8/15 at 11:50 AM indicated Home Health did occasionally drop off papers to be uploaded into the facility system, but there was nothing on site more recent than the 12/24/15 visit note. She further indicated she was contacting Home Health to update their records.</p> <p>Interview with Resident #4 on 2/8/15 at 2:40 PM, indicated she was receiving visits from Home Health weekly for ongoing wound care, was no longer going to the Wound clinic for treatment, and</p>		<p>3) Measures put into place / System changes :</p> <p>Franciscan Home Health was notified of the need for documentation of weekly visits and communications to be provided to facility after each visit to ensure collaboration of services.</p> <p>Visit notes will be faxed to facility by home health service weekly the next business day following visits. Documentation will be reviewed by Director of Nursing or designee and scanned into the electronic record, and updates made to service plan and/or physician orders as indicated.</p> <p>4) How the corrective actions will be monitored :</p> <p>The Director of Nursing and/ or designee will audit records of all residents receiving home health services weekly x30 days, then monthly thereafter to ensure compliance with documentation and accuracy of orders and service plans.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 consecutive months.</p>	

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R 0410 Bldg. 00	<p>was waiting on a special order knee brace from Home Health to facilitate support for transfers.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure a resident had a documented two step Mantoux (test for tuberculosis) completed upon admission into the facility for 1 of 7 residents</p>	R 0410	<p>Date of compliance: 3/4/2016</p> <p>R 410</p> <p>The facility requests paper compliance for this citation.</p> <p>This Plan of Correction is the</p>	03/04/2016

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	<p>reviewed for Mantoux's in a total sample of 7. (Resident #7)</p> <p>Finding includes:</p> <p>The record for Resident #7 was reviewed on 2/8/16 at 9:20 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and dementia. The resident was admitted to the facility on 5/11/15.</p> <p>The resident had a Mantoux administered on 3/19/15 and was read on 3/22/15 prior to her admission to the facility.</p> <p>There was a lack of documentation to indicate the resident had a second step Mantoux completed one to three weeks after the first step.</p> <p>Interview with the Director of Nursing on 2/8/16 at 1:08 p.m., indicated the second step Mantoux had not been completed.</p>		<p>center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the acts alleged or conclusions set forth in the statement of deficiencies . The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>1) Immediate actions taken for those residents identified :</p> <p>Resident # 7 was assessed and a two –step mantoux was scheduled to ensure compliance.</p> <p>2) How the facility identified other residents :</p> <p>An audit was performed on all other residents to ensure PPD testing was performed as required.</p> <p>3) Measures put into place / Systemic changes :</p> <p>Nurses will be re-educated regarding PPD testing requirements.</p> <p>4) How the corrective actions will be monitored :</p>		

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			<p>The Director of nursing or designee will audit all new admissions by the next business day to ensure first step PPD testing is scheduled and completed as required. A follow up audit will be performed within 21 days to ensure second step PPD has been completed.</p> <p>The Director of Nursing or designee will audit resident records at least quarterly thereafter to ensure annual PPD testing is performed as required.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved times 3 consecutive months.</p> <p>5) Date of compliance : 3/4/16</p>	