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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155683 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 09/17/2013 |
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| NAME OF PROVIDER OR SUPPLIER B & B CHRISTIAN HEALTHCARE CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 3208 N SHERMAN DR INDIANAPOLIS, IN 46218 |
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| F000000 | <p>This visit was for a Recertification and State Licensure Survey.</p> <p>Dates of Survey: September 10-17, 2013</p> <p>Facility number: 011032 Provider number: 155683 AIM number: 200262860</p> <p>Survey team: Courtney Mujic, RN-TC Karina Gates, BHS</p> <p>Census bed type: NF: 30 Total: 30</p> <p>Census payor type: Medicaid: 29 Other: 1 Total: 30</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> | F000000 | Please accept this as our credible allegation of compliance. | |
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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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| F000274 SS=D | <p>483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE</p> <p>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>Based on interview and record review, the facility failed to complete a significant change MDS (minimum data set) assessment for a resident with a functional decline in more than 2 areas for 1 of 16 residents reviewed for MDS assessments. (Resident #15)</p> <p>Findings include:</p> <p>The clinical record for Resident #15 was reviewed on 9/17/13 at 10:00 a.m.</p> <p>The diagnosis for Resident #15 included, but was not limited to: Alzheimer's disease.</p> <p>The 4/4/13 significant change MDS</p> | F000274 | <p>All charts were audited for change in each resident's status. The restorative book was audited for July, August, September. No other significant changes in the residents were found. No other changes were needed. Resident number 16 was an oversight, and it was too late to correct her MDS. However, all other resident's charts were audited thoroughly. All others had the potential to be affected by this deficient practice. However, after auditing all the resident's charts, no other significant changes were found. All nurses and c.n.a.'s were inserviced over significant changes in a resident. The inservice consisted of true and false questions and a question and answer session. Each nurse and c.n.a. was given an insert with all the areas that could</p> | 09/20/2013 |

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| | <p>indicated Resident #15 was independent, requiring no help or staff oversight at any time, in the following ADL's (activities of daily living): bed mobility, transfer, eating and toilet use.</p> <p>The 6/27/13 quarterly MDS indicated Resident #15 declined 3 levels requiring extensive assistance (resident involved in activity, but staff provided weight-bearing support), with the previously mentioned ADL's: bed mobility, transfer, eating and toilet use.</p> <p>The 4/4/13 significant change MDS indicated Resident #15 required supervision (oversight, encouragement or cueing) for the following ADL's: dressing and locomotion on unit.</p> <p>The 6/27/13 quarterly MDS indicated Resident #15 declined 3 levels to total dependence (requiring full staff performance every time during entire 7-day assessment period) with the previously mentioned ADL's: dressing and locomotion on unit.</p> <p>The 7/10/13, 6:00 a.m. nurses note indicated, "...Ambulance arrived...transfer to (name of hospital) via stretcher."</p> | | <p>denote a significant change in a resident. A book with significant change slips has been placed at the nursing station. The charge nurse must write, in the book, any change they denote in a resident. All c.n.a.'s will report any decline to the charge nurse. The MDS Coordinator will monitor the book for changes. When there is enough significant change, the MDS Coordinator will complete a significant change assessment. This book will be monitored bi-weekly by the D.O.N. and the MDS Coordinator. Any significant change will be reported to the Administrator. Addendum:Resident number 16 was a typographical error. The correct number is resident number 15. There was no tag for resident number 16. Tag 274 was answered for resident number 15.</p> | | |

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| | <p>The 7/10/13, 9:40 a.m. nurses note indicated, "(Name of doctor) called to inform facility that RHC'd (respirations have ceased)..."</p> <p>During an interview with RN #7 on 9/17/13 at 12:34 p.m., she indicated, "I see where she declined in those areas."</p> <p>During an interview with the Social Services Director on 9/17/13 at 12:34 p.m., she indicated, "She was a total decline in multiple areas. I see why a sig change (significant change MDS) probably should have been done."</p> <p>The MDS Coordinator was unavailable for interview.</p> <p>3.1-31(d)(1)</p> | | | | |

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| F000279 SS=D | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive 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 interview and record review, the facility failed to create a care plan for the diagnosis of insomnia and the usage of a medication for the treatment of insomnia for 1 of 16 residents reviewed for care plans. (Resident #31)</p> <p>Findings include:</p> <p>Review of Resident #31's clinical record, on 9/11/2013 at 2:40 p.m., indicated the resident's medications included Ambien (a medication used</p> | F000279 | A diagnosis for the psychotropic medication was obtained from the doctor. The psychotropic medication was care planned by the Social Services Director. All residents could have been affected by this deficient practice. However, no others were affected. All the charts were audited by the D.O.N. and the Social Services Director. All were found to be in compliance. No other psychotropic drugs, without the proper diagnosis, were found. All care plans were in place. These were audited by the MDS Coordinator and the Inservice Director. A box has | 09/27/2013 |

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| | <p>in the treatment of insomnia). The resident's clinical record was further reviewed on 9/16/2013 at 3:15 p.m. Diagnoses included, but were not limited to; GERD (gastroesophageal reflux disease,) depression, diabetes, hypertension, cerebrovascular accident (stroke), and seizure disorder. A care plan related to insomnia or the usage of the medication Ambien could not be found in the clinical record.</p> <p>A doctor's order, dated 8/22/2013, indicated, "zolpidem (Ambien) 5mg po (by mouth) q (every) HS (hour of sleep)."</p> <p>An interview with the Director of Nursing (D.O.N.), on 9/17/2013 at 8:55 a.m., indicated Resident #31 did not have the diagnosis of insomnia documented, nor did he have it care planned. "It was missed." She already told the Social Services Director and had her create a care plan for the resident's insomnia.</p> <p>A Pharmacy order, dated 9/16/2013 with no time specified, indicated, "Add to diagnosis: insomnia."</p> <p>3.1-35(a)</p> | | <p>been placed at the nursing station for all new orders. All new orders will be checked daily by the Inservice Director and weekly by the Social Services Director and D.O.N.This will be monitored monthly by the MDS Coordinator and quarterly by the QA Committee.</p> | |

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| F000282 SS=D | <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to administer the correct dosage of a medication as ordered by the physician to 1 of 4 residents observed during medication administration. (Resident #1)</p> <p>Findings include:</p> <p>An observation, on 9/17/2013 at 9:00 a.m., of QMA #1 administering medication indicated Resident #1 received a pill from a pill pack labeled "Lexapro 10mg".</p> <p>A physician order, dated 6//25/2013, indicated, "symbol for downward arrow (decrease) Lexapro to 5mg po (by mouth) QD (every day)."</p> <p>Review of Resident # 1's "Medication Record" indicated, "09/01/2013 through 09/30/2013. Lexapro 5mg tablet. Take 1 tablet by mouth once daily. Diagnosis: Schizophrenia".</p> <p>An observation and interview on 9/17/2013 at 9:50 a.m. with QMA #1</p> | F000282 | <p>A new policy and procedure was put in place on how to discard discontinued medication. All discontinued medication will be immediately removed from the medication cart by the nurse taking the order. The medication will be placed in the locked medication room for proper disposal. The physician and the family were notified of the medication error. The nurses and qma's were inserviced over the new policy. Each nurse and qma were observed doing a medication pass. The basics were gone over with each one and they are: The right medication, the right patient, the right dose, the right time, the right route, and the right documentation. A copy of the policy will be placed in the medication book. A color coded sheet with the medication rights will also be placed on the front of all of the medication books. All other residents were identified as having the potential to be affected by this deficient practice. No others were found to be affected. A new policy was put in place. Each nurse and qma was individually monitored during a med pass. The policy is in the</p> | 09/26/2013 |

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| | <p>and the Director of Nursing (D.O.N.) indicated the pill pack in the med cart was the 10mg dose, the wrong dosage.</p> <p>An interview with the D.O.N. on 9/17/2013 at 10:05 a.m. indicated the pharmacy delivered the medications at night, so the night nurse checked the medications and put them into the medication cart.</p> <p>An interview and observation with the D.O.N., on 9/17/2013 at 10:10 a.m., indicated the mistake happened because the old pill pack was left in the medication cart. Resident #1's Lexapro was decreased from 10mg to 5mg in June, 2013. The delivery date on the 10mg dosage pack was 6/21/2013. The 5mg dosage pack was also in the med cart, the delivery date on that was 8/28/2013. She indicated it is the policy of the facility to return all unused medications to the pharmacy.</p> <p>3.1-37(a)</p> | | <p>medication book. A color coded sheet with the medication rights is in the front of each med book. A bin has been put at the nursing station where all medication changes will be placed. The D.O.N. will monitor this bin. This will be monitored weekly by the D.O.N. and quarterly by the QA Committee.</p> | | |

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| F000287 SS=A | <p>483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT</p> <p>(1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. <p>(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.</p> <p>(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's | | | |

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| | <p>transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.</p> <p>(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>Based on interview and record review, the facility failed to transmit a resident's quarterly MDS to the State for 1 of 16 residents reviewed for MDS assessments. (Resident #7)</p> <p>Findings include:</p> <p>The clinical record for Resident #7 was reviewed on 9/17/13 at 11:00 a.m.</p> <p>The diagnosis for Resident #7 included, but was not limited to: bipolar disorder.</p> <p>The paper version of the 7/11/13 quarterly MDS assessment was reviewed, but could not be reviewed via computer.</p> <p>During an interview with RN #7, on 9/17/13 at 12:34 p.m., regarding whether Resident #7's 7/11/13 quarterly MDS was transmitted to the State in August, 2013, she stated,</p> | F000287 | <p>All of the MDS' were audited. There were some that were late. The late ones were corrected, if needed, and are in the process of being transmitted. At this time, all of the MDS' are in the process of being completed and will be transmitted by the end of the month. All of the residents had the potential of being affected by this deficient practice. The Administrator worked with the MDS Coordinator and put a plan in place in which all MDS' will be completed and transmitted within the required timeframe. At the present, the MDS Coordinator is completing the MDS' and the Business Office Manager is transmitting them. Beginning Nov 1, 2013, the MDS Coordinator will complete and transmit all MDS'. This will be monitored by the Administrator. Monthly, he will obtain a list of all MDS's that are due. He will monitor for timely completion and transmission.</p> | 10/31/2013 |

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| | <p>"No, (last name of Resident #7) did not get transmitted."</p> <p>The MDS Coordinator was unavailable for interview.</p> <p>3.1-31(h)</p> | | | |

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| F000371 SS=F | <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to properly thaw frozen meat and maintain the kitchen and dry storage area in a condition which protected stored foods from potential infestation. This had the potential to affect 29 of 29 residents who eat food from the kitchen.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted with the DM (Dietary Manager) on 9/10/13 at 12:20 p.m.</p> <p>The dry storage area was observed with a pair of red and white sneakers under a dry storage rack as well as 5 packets of sugar, 1 packet of pepper, onion peels, a pack of saltine crackers, a box of pudding, and a straw. The DM stated, "None of that should be there. I'll take care of it."</p> <p>A small, black, fast moving bug was observed crawling on the floor in the</p> | F000371 | <p>The kitchen was immediately cleaned. The Maintenance Supervisor cleaned and painted the base boards. The floor was deep cleaned and degreased. The Dietary Supervisor cleaned and degreased the stove. All items that did not belong in the kitchen were removed. The pantry and closet were cleaned. The thawing meat was removed and separated into different pans. A policy was written that no unlike meats will be thawed together. Meats will be separated into separate leak proof pans and placed in the bottom of the refrigerator. All residents were identified as having the potential to be affected by the deficient practice. A policy on thawing meat and food was inserviced one on one with all dietary staff. A new procedure for thawing food will be posted on the refrigerator door. A cleaning schedule will be posted in the kitchen. The cleaning schedule will be monitored weekly by the Dietary Manager, bi-weekly by the Maintenance Supervisor, and monthly by the Dietary Consultant. Addendum: Policy for</p> | 09/25/2013 | |

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| (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>dry storage area. The DM stated, "The bugman sprayed in here last week."</p> <p>Dirt and debris were observed in the corners and along the baseboards of the dry storage area. The DM stated, "I haven't cleaned the baseboards in 60 days. It's on my list for this weekend."</p> <p>There was observed in the refrigerator a bag of frozen chicken, thawing in a metal pan with 2 packs of smoked sausage thawing on top of the frozen chicken in the same pan. Bloody water was in the bottom of the pan. The DM stated, "They should be in separate pans."</p> <p>The floor area behind the stove was observed with grease along the floor and baseboards. It looked sticky with gunk and debris particles stuck in the grease. The DM stated, "All baseboards will be done this weekend. It should be done monthly. I haven't done it in 60 days."</p> <p>Review of the 8/22/2013 pest control log indicated the facility had been treated for mice and roaches.</p> <p>3.1-21(i)(3)</p> | | <p>thawing food.Purpose: To ensure that all foods are thawed properly and safely.Procedure: 1. The dietary cook will pull the food for the next day immediately after breakfast is finished. 2. The frozen foods will be placed in a leak proof container at the bottom of the refrigerator. 3. All unlike foods will be placed in separate pans. 4. All frozen foods will have 24 hours to thaw.</p> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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