

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155297	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/25/2013
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NAME OF PROVIDER OR SUPPLIER CONTINUING CARE CENTER OF LAPORTE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 21, 22, 23, 24, and 25, 2013</p> <p>Facility number: 000194 Provider number: 155297 AIM number: 100267790</p> <p>Survey team: Lara Richards, RN, TC Heather Tuttle, RN Yolanda Love, RN Julie Ferguson, RN (10/21, 10/22, 10/24, and 10/25/13)</p> <p>Census bed type: SNF: 26 SNF/NF: 16 Total: 42</p> <p>Census payor type: Medicare: 20 Medicaid: 11 Other: 11 Total: 42</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October</p>	F000000		
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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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	31, 2013, by Janelyn Kulik, RN.			

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and interview, the facility failed to ensure each residents' dignity was maintained related to residents being called "feeders" for 1 of 2 meals observed. (Resident #73)</p> <p>Findings include:</p> <p>On 10/21/13 at 12:42 p.m., two meal trays were observed in the 5th floor dining area. CNA #1 indicated one of the residents was in a procedure and they would order her a new tray when she got back. She then indicated the other tray was for Resident #73, who was a "feeder."</p> <p>Interview with the Director of Nursing on 10/24/13 at 9:00 a.m., indicated the resident should not have been identified as a "feeder" and she would educate the staff.</p> <p>3.1-3(t)</p>	F000241	<p>F2411. CNA responsible for referring to resident #73 as a "feeder" during the survey observed meal pass was educated on 10/21/13 at the time of occurrence by the RN Case Manager regarding the inappropriate use of this terminology regarding resident. In addition, this CNA was re educated during the all staff inservice on 11/11/13 regarding review of resident right of dignity explanation and what is considered respectful reference of a resident.2. All Continuing Care Center residents who require feeding assistance were at risk to be referred to by this inappropriate terminology. They were identified by the "feeder" designation on the CNAs resident care profile sheet they carry daily. This designation on the profile sheet has been removed and replaced with a new more respectful term. 3. The care assistance designation of "feed" / "feeder" has been removed from the CNA resident care profile sheet and replaced with the care designation of "meal assistance required". (see attached copy of corrected resident care profile</p>	11/12/2013	

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			sheet) In addition, all CCC staff were inserviced on November 11th, 2013 on the resident right of dignity and the appropriate and respectful way to refer to residents and how to address residents appropriately. (see attached inservice content sheet and signature sheet)4. There will be a random ongoing observation of meal and tray pass done at least weekly by the DNS or her designee. Observation will be to determine staff's verbal reference to residents needing meal assistance and if they are appropriate and respectful. Any concerns noted will be addressed immediately at the time of observation with the responsible staff member and observation results documented on the POC weekly rounds sheet. (see attached copy of weekly rounds documentation)		

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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, record review, and interviews, the facility failed to ensure the resident's care plan was followed related to monitoring and assessing a fistula shunt used for dialysis for 1 of 1 residents reviewed for dialysis. (Resident #168)</p> <p>Findings include:</p> <p>On 10/23/13 at 11:24 a.m., Resident #168 was observed sitting on the side of his bed in his room. At that time, he was observed with a fistula shunt that was covered with white bandages to his left arm.</p> <p>The record for Resident #168 was reviewed on 10/23/13 at 12:55 p.m. The resident was admitted to the facility on 10/15/13 from the hospital. The resident's diagnoses included, but were not limited to, dialysis, end stage renal disease, hypothyroidism, congestive heart failure and high blood pressure.</p> <p>Review of the current plan of care dated 10/15/13, indicated the resident</p>	F000282	F2821. Documentation area for assessment of dialysis fistula site and pre and post dialysis vitals was added to resident #168 MAR on 10/23/13 during the survey process. These were performed and recorded daily until resident's discharge on 11/04/13. (see attached copies of res#168 MAR) In addition the careplan for resident #168 was also updated to include the check for the fistula bruit and thrill check, which is also part of the recorded documentation on the MAR. (see copy of updated careplan for res# 168)2. The current Continuing Care resident population was audited and there is only one additional dialysis resident who was admitted on 10/29/13 post survey. This resident and any future dialysis resident admitted to CCC has the potential to be at risk for failure of staff to comply with careplan interventions and have no supporting documentation of assessment pre and post dialysis. Upon medical record review of this resident RW the admitting nurse added the fistula site assessment, bruit and thrill check, and pre and post dialysis vital signs checks to resident's MAR. These have	11/12/2013			

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	<p>had a left arm fistula that was used for dialysis. The Nursing approaches were to monitor the fistula daily for signs and symptoms of infection.</p> <p>Review of another current plan of care dated 10/15/13, indicated the resident needed hemodialysis. The Nursing approaches were to check and change the dressing daily at the access site and monitor for signs and symptoms of infection.</p> <p>Review of the Treatment Administration Record (TAR) for the month of October 2013, indicated there was no evidence of any documentation the fistula site had been monitored and assessed daily as well as changing the bandages.</p> <p>Review of Nursing Progress Notes dated 10/15-10/23/13, indicated there was no evidence of any documentation the resident's fistula site had been monitored or assessed daily.</p> <p>Interview with RN #1 on 10/23/13 at 1:10 p.m., indicated she did not assess the resident's fistula site and check for the thrill or listen for the bruit. She further indicated she had not ever changed the resident's bandages either for his site.</p>		<p>been completed and documented since admission. (see copies of resident RW's MAR attached) A comprehensive dialysis assessment careplan and interventions has been completed for resident RW as well (see attached copy) and a master of a comprehensive careplan has been added electronically to the CCC nursing careplan library for use to be individualized for future dialysis residents.3. The Continuing Care Center team has developed and implemented a new pre and post dialysis assessment form to be completed before and after all dialysis on any resident receiving this procedure. The assessment includes vital signs, shunt/fistula site check for infection, bleeding, and bruit and thrill check and an assessment of a central line access if appropriate. It reflects documentation if any physician notification is made and why, as well as date, time and signature of the assessing nurse. Each form will contain one week's worth of documentation for a resident with dialysis three times per week. (see attached copy of dialysis assessment form) All licensed nurses were inserviced on the new assessment form and it's use as well as appropriate dialysis assessment pre and post treatment at an inservice on November 11th, 2013. Nurses were also informed of consequences for not being</p>				

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	3.1-35(g)(2)		compliant with required documentation. (see attached inservice content and signature sheet)4. There will be routine monitoring of nurses compliance with the pre and post dialysis assessment form weekly by the DNS or her designee. Any deficiencies will be documented on the dialysis monitoring log sheet and addressed with the responsible nurse at the time it is found. Repetitive failure of any nurse to comply with required documentation will result in formal disciplinary action. (see attached copy of dialysis assessment monitoring log)		

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 interviews, the facility failed to ensure each resident received the necessary treatment and services related to monitoring and assessing a fistula shunt used for dialysis for 1 of 1 residents reviewed for dialysis. (Resident #168)</p> <p>Findings include:</p> <p>On 10/23/13 at 11:24 a.m., Resident #168 was observed sitting on the side of his bed in his room. At that time, he was observed with a fistula shunt that was covered with white bandages to his left arm.</p> <p>The record for Resident #168 was reviewed on 10/23/13 at 12:55 p.m. The resident was admitted to the facility on 10/15/13 from the hospital. The resident's diagnoses included, but were not limited to, dialysis, end stage renal disease, hypothyroidism, congestive heart failure and high blood pressure.</p>	F000309	F3091. Documentation area for assessment of dialysis fistula site and pre and post dialysis vitals was added to resident #168 MAR on 10/23/13 during the survey process. These were performed and recorded daily until resident's discharge on 11/04/13. (see attached copies of res#168 MAR) In addition the careplan for resident #168 was also updated to include the check for the fistula bruit and thrill check, which is also part of the recorded documentation on the MAR. (see copy of updated careplan for res# 168) RN interviewed by surveyor was educated by DNS on 10/24/13 regarding appropriate pre and post dialysis assessment as well as RN was educated with all CCC nurses through formal inservice on November 11th, 2013 reviewing all the steps of appropriate pre and post dialysis care and assessment. 2. The current Continuing Care resident population was audited and there is only one additional dialysis resident who was admitted on 10/29/13 post survey. This resident and any future dialysis	11/12/2013			

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	<p>Review of Physician Orders dated 10/15/13, indicated the resident was to receive hemodialysis every Tuesday, Thursday, and Saturday.</p> <p>Review of the current plan of care dated 10/15/13, indicated the resident had a left arm fistula that was used for dialysis. The Nursing approaches were to monitor the fistula daily for signs and symptoms of infection.</p> <p>Review of another current plan of care dated 10/15/13, indicated the resident needed hemodialysis. The Nursing approaches were to check and change the dressing daily at the access site and monitor for signs and symptoms of infection.</p> <p>Review of the Treatment Administration Record (TAR) for the month of October 2013, indicated there was no evidence of any documentation the fistula site had been monitored and assessed daily as well as changing the bandages.</p> <p>Review of Nursing Progress Notes dated 10/17/13, (Thursday) at 12:00 a.m., 2:00 p.m., and 10:00 p.m., indicated there was no evidence of any documentation the resident's fistula site was assessed or</p>		<p>resident admitted to CCC has the potential to be at risk for failure of staff to comply with careplan interventions and have no supporting documentation of assessment pre and post dialysis. Upon medical record review of this resident RW the admitting nurse added the fistula site assessment, bruit and thrill check, and pre and post dialysis vital signs checks to resident's MAR. These have been completed and documented since admission. (see copies of resident RW's MAR attached) A comprehensive dialysis assessment careplan and interventions has been completed for resident RW as well (see attached copy) and a master of a comprehensive careplan has been added electronically to the CCC nursing careplan library for use to be individualized for future dialysis residents.3. The Continuing Care Center team has developed and implemented a new pre and post dialysis assessment form to be completed before and after all dialysis on any resident receiving this procedure. The assessment includes vital signs, shunt/fistula site check for infection, bleeding, and bruit and thrill check and an assessment of a central line access if appropriate. It reflects documentation if any physician notification is made and why, as well as date, time and signature of the assessing nurse. Each</p>		

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	<p>monitored.</p> <p>Review of Nursing Progress Notes for 10/19/13, (Saturday) indicated there was no documentation at all for that day.</p> <p>Review of Nursing Progress Notes dated 10/22/13 (Tuesday) at 6:00 a.m., indicated there was no evidence of any documentation of the resident's fistula site being assessed or monitored for bleeding or infection before and after dialysis.</p> <p>Review of Nursing Progress Notes dated 10/15-10/23/13, indicated there was no evidence of any documentation the resident's fistula site had been monitored or assessed daily.</p> <p>Review of the vital signs record indicated the resident's blood pressure was documented on the following dates and time: 10/17 at 6:52 a.m. 10/17 at 10:20 p.m. 10/19 at 12:24 p.m. 10/19 at 9:26 p.m. 10/22 at 7:03 a.m. 10/22 at 3:07 p.m.</p> <p>Interview with RN #1 on 10/23/13 at 1:10 p.m., indicated the resident</p>		<p>form will contain one week's worth of documentation for a resident with dialysis three times per week. (see attached copy of dialysis assessment form) All licensed nurses were inserviced on the new assessment form and it's use as well as appropriate dialysis assessment pre and post treatment at an inservice on November 11th, 2013. Nurses were also informed of consequences for not being compliant with required documentation. (see attached inservice content and signature sheet)4. There will be routine monitoring of nurses compliance with the pre and post dialysis assessment form weekly by the DNS or her designee. Any deficiencies will be documented on the dialysis monitoring log sheet and addressed with the responsible nurse at the time it is found. Repetitive failure of any nurse to comply with required documentation will result in formal disciplinary action. (see attached copy of dialysis assessment monitoring log)</p>		

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	<p>usually left the facility around 8:30 a.m. and returned around 1:30 p.m. She further indicated she did not assess the resident's fistula site and check for the thrill or listen for the bruit before he left for dialysis or after he returned. She further indicated she had not ever changed the resident's bandages either for his site. The RN further indicated she did not routinely check the resident's vital signs before or when returning to the facility.</p> <p>Interview with Case Manager #1 on 10/23/13 at 2:20 p.m., indicated the facility had no policy for dialysis or monitoring of the fistula shunt for the residents who were receiving dialysis.</p> <p>Interview with the Director of Nursing on 10/24/13 at 9:10 a.m., indicated the nurses were to assess and monitor the fistula on a daily basis.</p> <p>3.1-37(a)</p>				

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, record review and interview, the facility failed to ensure multi dose vials of medication were discarded after the expiration date on 1 of 2 units throughout the facility. (The Sixth floor and Resident #7)</p> <p>Findings include:</p> <p>1. On 10/25/13 at 10:29 a.m., a vial of Novolog insulin for Resident #7 was dated as being opened 9/23/13. A white sticker on the vial indicated the insulin was to be discarded after 28 days.</p>	F000425	F 4251. Both the vial of Novolog insulin that was expired on 10/22/13 for resident # 7 was removed on 10/25/13 during survey and destroyed. A new vial was re-ordered and recieved from In Touch Pharmacy for resident # 7. The multi dose vial of PPD solution on 6th floor which expired 10/20/13 was removed from the med refrigerator on 10/25/13 during survey and was destroyed. A decision was made by ED and DNS that going forward when a 6th floor resident needs a PPD given the nurse will obtain a dose from the 5th floor supply. This is to help eliminate the risk of vials sitting in fridge	11/12/2013			

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	<p>Interview with LPN #1 at the time, indicated the insulin was to be discarded 28 days after opening.</p> <p>2. On 10/25/13 at 10:35 a.m., a vial of house stock Tuberculin Purified Protein (TB testing solution) was observed in the Sixth floor medication refrigerator. The vial was dated as being opened on 9/20/13. A white sticker on the vial indicated the TB solution was to be discarded 30 days after opening.</p> <p>Interview with Case Manager #1 on 10/25/13 at 11:00 a.m., indicated no residents had received a PPD (TB test) on the Sixth floor since 10/20/13.</p> <p>Interview with the Director of Nursing on 10/25/13 at 11:25 a.m., indicated the insulin vial should have been discarded after 28 days and the vial of tuberculin solution should have been discarded after 30 days.</p> <p>Review of the facility policy "Expiration Dates of Medications" on 10/25/13 at 11:25 a.m., which was provided by the Director of Nursing and identified as current, indicated the following:</p> <p>Insulin vials expire 28 days after</p>		<p>unused for long periods due to limited use compared to high volume use on 5th floor. 2. All residents who receive insulin and all residents who require PPDs are potentially at risk to be affected by an expired medication vial. There was a complete audit of all medication carts and medication refrigerators on both 5th and 6th floors done by In Touch Pharmacy staff on 10/31/13 to ensure that all current medications for all residents is safe and not expired. (see attached copy of pharmacy cart and refrigerator audits 10/31/13)</p> <p>3. Ongoing monitoring for the potential risk for expired medications will be done routinely with monthly consultant pharmacy visits and documented in their consulting reports to DNS. All licensed nurses were inserviced on November 11th, 2013 on the pharmacy policy for time frames of multi dose vial medications. (see copy of Appendix 22 with inservice signature sheet) Nurses were informed that this is their responsibility to monitor expiration dates for all medications during their daily medication administration process.4. There will be an ongoing weekly random check of medication refrigerators and medication carts both on 6th and 5th floors by DNS or her designee and results documented on the weekly POC rounds sheet. Any concerns noted at that time will</p>				

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NAME OF PROVIDER OR SUPPLIER CONTINUING CARE CENTER OF LAPORTE HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350		
(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	
	opening. Tuberculin test (TB test) refrigerate until ready to use. Date when opened and discard unused portion after 30 days. 3.1-25(o)		be addressed with the responsible licensed nurse, pharmacy if appropriate, and corrected immediately. (see attached copy of weekly POC rounds sheet)		