

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2016
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NAME OF PROVIDER OR SUPPLIER  HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
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R 0000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: July 19, 20, and 21, 2016</p> <p>Facility number: 005722 Provider number: 005722 AIM number: N/A</p> <p>Census bed type: Residential: 106 Total: 106</p> <p>Sample: 8</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Q.R. completed by 14466 on July 27, 2016.</p>	R 0000	The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
R 0036  Bldg. 00	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency</p> <p>(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:</p> <p>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or</p> <p>(2) a need to alter treatment significantly, that is, a need to discontinue an existing</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's physician was notified of a severe weight loss of greater than 7.5% in 3 months for 1 of 7 residents reviewed for physician notification. (Resident #94)</p> <p>Findings include:</p> <p>The clinical record of Resident #92 was reviewed on 7/19/16 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease and dysphagia (difficulty swallowing).</p> <p>A physician's order dated 3/25/16, indicated Resident #92 was to receive a mechanical soft diet (food mechanically altered to make chewing and swallowing easier) with thickened liquids. The resident could also receive comfort foods (foods he especially enjoyed eating). On 9/21/16 at 11:18 a.m., the General Manager indicated the diet order of 3/25/16, was current.</p> <p>A Service Plan for Resident #92, dated 3/9/16, indicated he, "...requires mirror imaging, cueing, or hand-over-hand assistance with eating."</p>	R 0036	<p>RESIDENTS' RIGHTS DEFICIENCY – (R036)</p> <p>1. Resident #92's current physician and family were notified of weight loss. New order was obtained for double portion and Ensure supplement twice a day for Resident #92's. Weekly weights will be obtained for resident #92 and reviewed until weight stabilizes. Dietician reviewed resident #92's chart on 08/04/2016 and gave recommendations of 8 ounce whole milk with the Ensure in between meals to maximize meal intake. Current weight for resident #92 is 120.8pounds, which is a 4.8 pound weight gain since the 07/20/2016 weight obtained. 2. Wellness director has audited the monthly vital sign records of each resident on memory care to identify any weight loss and has reported any findings of significance to the current primary physician and family. No other greater 7.5% weight loss over three months or 5 pound weight loss over 30 days was identified for any other residents. 3. Wellness director/designee will review monthly weights for each memory care resident in comparison to three month historical weights to ensure that any weight loss greater than 7.5% in three months or 5 pounds weight loss</p>	08/20/2016			

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	<p>Observations of Resident #92 on 7/19/16 at 12:25 p.m., 7/20/16 at 10:20 a.m., and 7/21/16 at 10:35 a.m., indicated he ate all food served to him.</p> <p>Review of Resident #92's weights indicated:</p> <p>2/7/16 weight = 136 2/20 16 weight = 146 3/9/16 weight = 133.8 4/4/16 weight = 136.2 5/5/16 weight = 131 6/20/16 weight = 126 7/20/16 weight 116</p> <p>Weight loss between 2/20/16 and 5/5/17 = 10.2% This is a severe weight loss of greater than 7.5% in 3 months</p> <p>Weight loss between 4/4/16 and 6/20/16 = 7.3% This is a severe weight loss of greater than 7% in 2 months</p> <p>Weight loss between 4/4/16 and 7/20 16 = 14.7% This is a severe weight loss of greater than 7.5% in 3 months</p> <p>No documentation was found in Resident #92's record which indicated the physician was notified, nor new dietary interventions were implemented between April, 2016 and 7/20/16.</p>		<p>in 30 days has been documented and physician and family notification has occurred. Wellness director will communicate any residents with weight loss greater than 7.5% in three months or 5 pounds weight loss in 30 days to executive director. Communication form will be utilized to ensure physician notification has occurred. An in-service was conducted on 08/04/2016 by wellness director to licensed nurses on these procedures to ensure policy and procedure and documentation are completed.</p> <p>4. Wellness directors/designee will audit the vital sign reports monthly for any concerns and will report the concerns to the physician and family. General manager will audit communication forms monthly to ensure proper documentation and reporting. Any documented weight loss of greater than 7.5% over three months or 5 pounds weight loss over 30 days will be reviewed at quarterly quality assurance meetings to ensure all proper procedures have been followed. 5. These systematic changes will be completed by 08/20/2016.</p>	

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R 0273 Bldg. 00	<p>On 7/20/16 at 3:00 p.m., the Wellness Director indicated weights should be done monthly and reviewed for weight loss trends so dietary interventions could be implemented.</p> <p>On 7/20/16 at 11:20 a.m., the General Manager indicated she was not able to find any documentation from April, 2016 through 7/20/16, regarding recognition of Resident #92's severe weight losses, nor that the physician had been notified.</p> <p>On 9/21/16 at 9:48 a.m., the General Manager provided a policy titled, "Resident Weight Monitoring," dated 4/26/16, and indicated it was the policy currently used by the facility. The policy indicated, "...Any fluctuation in weight of five or more pounds will be reported to physician and the dietitian will be notified as well..."</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review, facility failed to ensure prepared food items were covered before leaving the kitchen area as indicated by</p>	R 0273	FOOD AND NUTRITIONAL SERVICES DEFICIENCY- (R273) 1. No residents were affected by the alleged deficient practice. 2. No other food was	08/20/2016

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	<p>Retail Food Establishment Sanitation Requirements 410 IAC.</p> <p>Findings include:</p> <p>On 7/20/2016 at 8:40 a.m., observed a serving tray in the main dining room with 3 bowls of uncovered prepared oatmeal and 3 bowls of uncovered prunes. Kitchen staff served all food items on the tray, including the uncovered oatmeal and uncovered prunes.</p> <p>On 7/20/2016 at 10:00 a.m., during interview with the cook, the cook indicated all food items in dining room should have been covered before leaving kitchen area.</p> <p>On 7/20/2016 at 11:33 a.m., the General Manager (GM) provided the policy Food Safety, dated 1/6/2016, and indicated the policy was the one currently being used by the facility. "Purpose: ...To Provide food that is free from contamination thus risking the health and well being of the residents and staff. Procedure...1. All staff will be aware of proper handling and storage procedures."</p> <p>On 7/20/2016 at 11:59 a.m., during review of Retail Food Establishment Sanitation Requirements indicated, 410</p>		<p>identified as not being covered.</p> <p>3. Food service director/general manager have educated food service staff on appropriate food transportation procedures. Food leaving the kitchen area must be covered with plastic wrap or plate domes. 4. Food service director/dining room assistant manager/cookswill monitor that food being transported from the kitchen is covered everymeal/snack service seven (7) days a week.Food service director/designee will monitor food service operations one (1)meal daily for two (2) weeks, one (1) meal daily for one (1) week, and one (1)meal weekly for four (4) weeks, and monthly thereafter. 5. These systematic changes will be completed by 08/20/16.</p>	

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R 0275 Bldg. 00	<p>IAC Food Storage Sec. 177410. (c), food shall be protected from contamination by storing food as follows...5. In packages, covered containers or wrappings.</p> <p>410 IAC 16.2-5-5.1(h) Food and Nutritional Services - Deficiency (h) Diet orders shall be reviewed and revised by the physician as the resident ' s condition requires.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident's physician was notified, according to facility policy, of a severe weight loss of greater than 7.5% in 3 months, so the physician could review the resident's record for any needed dietary revisions. (Resident #92)</p> <p>Findings include:</p> <p>The clinical record of Resident #92 was reviewed on 7/19/16 at 2:00 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease and dysphagia (difficulty swallowing).</p> <p>A physician's order dated 3/25/16, indicated Resident #92 was to receive a mechanical soft diet (food mechanically altered to make chewing and swallowing</p>	R 0275	<p>FOOD AND NUTRITIONAL SERVICES DEFICIENCY- (R275)</p> <p>1. Resident #92's current physician and family were notified of weight loss. New order was obtained for double portion and Ensure supplement twice a day for Resident #92's. Weekly weights will be obtained for resident #92 and reviewed until weight stabilizes. Dietician reviewed resident #92's chart on 08/04/2016 and gave recommendations of 8 ounce whole milk with the Ensure in between meals to maximize meal intake. Current weight for resident #92 is 120.8pounds, which is a 4.8 pound weight gain since the 07/20/2016 weight obtained. 2. Wellness director has audited the monthly vital sign records of each resident on memory care to identify any weight loss and has reported any findings of significance to the</p>	08/20/2016

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	<p>easier) with thickened liquids. The resident could also receive comfort foods (foods he especially enjoyed eating). On 9/21/16 at 11:18 a.m., the General Manager indicated the diet order of 3/25/16, was current.</p> <p>A Service Plan for Resident #92, dated 3/9/16, indicated he, "...requires mirror imaging, cueing, or hand-over-hand assistance with eating."</p> <p>Observations of Resident #92 on 7/19/16 at 12:25 p.m., 7/20/16 at 10:20 a.m., and 7/21/16 at 10:35 a.m., indicated he ate all food served to him.</p> <p>Review of Resident #92's weights indicated:</p> <p>2/7/16 weight = 136 2/20 16 weight = 146 3/9/16 weight = 133.8 4/4/16 weight = 136.2 5/5/16 weight = 131 6/20/16 weight = 126 7/20/16 weight 116</p> <p>Weight loss between 2/20/16 and 5/5/17 = 10.2% This is a severe weight loss of over 7.5% in 3 months</p> <p>Weight loss between 4/4/16 and 6/20/16 = 7.3% This is a severe weight loss of</p>		<p>current primary physician and family. No other greater 7.5% weight loss over three months or 5 pound weight loss over 30 days was identified for any other residents. 3. Wellness director/designee will review monthly weights for each memory care resident in comparison to three month historical weights to ensure that any weight loss greater than 7.5% in three months or 5 pounds weight loss in 30 days has been documented and physician and family notification has occurred. Wellness director will communicate any residents with weight loss greater than 7.5% in three months or 5 pounds weight loss in 30 days to executive director. Communication form will be utilized to ensure physician notification has occurred. An in-service was conducted on 08/04/2016 by wellness director to licensed nurses on these procedures to ensure policy and procedure and documentation are completed. 4. Wellness directors/designee will audit the vital sign reports monthly for any concerns and will report the concerns to the physician and family. General manager will audit communication forms monthly to ensure proper documentation and reporting. Any documented weight loss of greater than 7.5% over three months or 5 pounds weight loss over 30 days will be</p>				

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	<p>over 7% in 2 months</p> <p>Weight loss between 4/4/16 and 7/20 16 = 14.7% This is a severe weight loss of over 7.5% in 3 months</p> <p>No documentation was found in Resident #92's record which indicated the physician was notified, the Registered Dietician consulted, nor new dietary interventions were implemented between April, 2016 and 7/20/16.</p> <p>On 7/20/16 at 3:00 p.m., the Wellness Director indicated weights should be done monthly and reviewed for weight loss trends so dietary interventions could be implemented.</p> <p>On 7/20/16 at 11:20 a.m., the General Manager indicated she was not able to find any documentation from April, 2016 through 7/20/16 regarding recognition of Resident #92's severe weight losses, nor that the physician and Registered Dietician had been notified.</p> <p>On 9/21/16 at 9:48 a.m., the General Manager provided a policy titled, "Resident Weight Monitoring," dated 4/26/16, and indicated it was the policy currently used by the facility. The policy indicated, "...Any fluctuation in weight of five or more pounds will be reported to</p>		<p>reviewed at quarterly quality assurance meetings to ensure all proper procedures have been followed. 5. These systematic changes will be completed by 08/20/2016.</p>				

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R 0349 Bldg. 00	<p>physician and the dietitian will be notified as well..."</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> <p>Based on record review and interview, the facility failed to ensure medical records were complete for residents requiring blood sugar monitoring (Resident #51 and #78), requiring blood pressure monitoring (Resident # 78 and #115), and administration of medications (Resident #78) for 3 of 8 residents reviewed for accurate and complete records.</p> <p>Findings include:</p> <p>1. a.) On 7/20/2016, at 9:00 a.m., the clinical record of Resident #51 was reviewed. Diagnosis included but not limited to diabetes type II uncontrolled, noncompliance with dietary regimen.</p>	R 0349	<p>CLINICAL RECORDS NONCOMPLIANCE (R349)</p> <p>1. No residents were affected by the alleged deficient practice. 2. On 7/20/2016, wellness director/designee reviewed all residents' electronic medication administration records requiring vital sign and/or testing prior to medication administration and verified that all documentation components within the EMAR software we reactivated. 3. Wellness director/general manager will educate all LPNs and QMAs on documentation procedures and reporting with regard to documenting vital signs and/or testing prior to medication administration. 4. Wellness director/designee will review electronic medication administration records on all new</p>	08/20/2016

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	<p>A recapitulation of physicians orders for July 2016, contained an order dated 4/4/16 (start date), indicated accuchecks (procedure to determine blood sugar level), check three times daily.</p> <p>A recapitulation of physicians orders for July 2016, contained an order dated 1/31/2016 (start date), indicated Humalog insulin subcutaneous (under skin), use per sliding scale (dosage depends on accucheck results.) Call physician if blood sugar &lt; (less than) 70 or &gt; (greater than) 400.</p> <p>Medication Administration Record (MAR) dated June 2016, indicated Resident #51's accucheck was to be performed at 9:00 a.m., 12:00 p.m., and 5:00 p.m., daily.</p> <p>MAR dated June 2016, indicated Resident #51's accucheck was not recorded at 5:00 p.m. on June 7, 8, 10, 11, 13, 15, 17, 26 and 27th.</p> <p>On 7/21/2016 at 9:48 a.m., during an interview with the General Manager (GM) indicated vital signs (including accuchecks) are part of the computer program where documentation (blood sugar results) occurs. The nurses were able to bypass screens without required</p>		<p>admissions and random residents with vital sign and/or testing requirements prior to administration of medication daily times one (1) week, weekly times two (2) weeks, monthly times four (4) weeks, and quarterly thereafter. 5. These systematic changes will be completed by 08/20/16.</p>	

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	<p>documentation. Part of the program "was not activated" at the time the accuchecks were showing as "not recorded." This has been "fixed" the nurses will not be able to leave the vital sign screen until a value (accucheck result) has been placed. The nurses should have put a note in the nurses notes, "instead they did nothing." GM indicated, If it (accuchecks results) were not documented; it is considered not done.</p> <p>b.) A Physician's order dated 3/28/16, current through 6/1/16, indicated Resident #78 was to have his blood sugar checked twice daily alternating between lunch and bedtime and between breakfast and dinner.</p> <p>A review of the MAR (Medication Administration Record) for May 2016, indicated the blood sugar was checked, but no results of blood sugar monitoring were documented at 9:00 a.m. on May 1, 2016; 5:00 p.m. on May 2 and 12; and at 9:00 p.m. on May 1 and 13.</p> <p>During an interview on 7/21/16 at 9:48 a.m., the General Manager (GM) indicated no documentation was found in Resident #78's clinical record indicating the blood sugar results on the dates mentioned above. The GM indicated vital signs (including blood sugars) are</p>			

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R 0410 Bldg. 00	<p>part of the computer program where documentation (blood sugars results) occurs. The nurses were able to bypass screens without required documentation. Part of the program "was not activated" at the time the accuchecks were showing as "not recorded." This has been "fixed" the nurses will not be able to leave the vital sign screen until a value (blood sugar result) has been placed. The nurses should have put a note in the nurses notes, "instead they did nothing." GM indicated, If it (blood sugar results) were not documented; it is considered not done.</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</p>			

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NAME OF PROVIDER OR SUPPLIER  HEARTH AT STONES CROSSING LLC THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2339 S SR 135 GREENWOOD, IN 46143
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	<p>to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on record review and interview, the facility failed to ensure annual and 2nd step tuberculin skin tests were administered for 3 of 7 residents reviewed for receiving tuberculin skin tests. (Resident #91, Resident #86 and Resident #78)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #86 was reviewed on 7/19/16 at 12:40 p.m. Diagnoses for the resident included, but were not limited to, Alzheimer's disease.</p> <p>Resident #86 was admitted to the facility on 6/22/16. The first step of a two-step tuberculin skin test was administered on 6/22/16. Results were negative. No documentation was found in Resident #86's record which indicated a 2nd step tuberculin skin test had been administered.</p> <p>On 7/21/16 at 11:18 a.m., the General Manager (GM) indicated a 2nd step tuberculin skin test had not been administered.</p> <p>2. The clinical record of Resident #91 was reviewed on 7/20/16 at 9:45 a.m.</p>	R 0410	<p>1. Three residents were affected by this noncompliance (#91, #78, and #86). Resident #78 had annual PPD administered on 7/13/2016, and Resident TB Risk Evaluation was completed by the physician documenting the resident is free of communicable disease. Resident #91 received 1st step PPD on 8/4/2016 and 2nd step on 8/17/2016. Resident #86 received new PPD on 8/15/2016 and Resident TB Risk Evaluation was completed by the physician documenting the resident is free of communicable disease. Next annual PPD information entered into electronic medication administration system for each resident. 2. Wellness director/designee will review resident charts to verify proper completion of annual TB skin tests have been completed and documented. 3. Wellness director/designee will educate staff on policies and procedures for TB skin test documentation of new admission, 2nd step, and annual TB skin tests. Wellness director/designee will educate staff on utilizing the electronic medication administration system to schedule TB skin tests, as well as the reading of the tests to ensure compliance. 4. Wellness director/designee will monitor the EMAR documentation for TB completion weekly times four (4)</p>	08/20/2016

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	<p>Diagnoses for the resident included, but were not limited to, dementia.</p> <p>The record of Resident #91 indicated she had received an annual tuberculin skin test on 6/8/15. The results were negative. No documentation was found in the resident's record which indicated the tuberculin skin test had not been administered since 6/8/15 (greater than 12 months).</p> <p>3. The clinical record for Resident #78 was completed on 7/19/16 at 12:05 p.m. Diagnoses included, but were not limited to, hypertension.</p> <p>The record of Resident #78 indicated he received a tuberculin skin test on 4/16/16.</p> <p>No other tuberculin test was documented until 7/12/16, approximately 3 months after it was due.</p> <p>On 7/21/16 at 1:45 p.m., the General Manager indicated Resident #78 was due for her annual skin test on 4/16/16, but it did not get done.</p> <p>The GM indicated the facility policy is to administer an annual tuberculin test within 12 months of the last documented test.</p>		<p>weeks, biweekly times two (2) weeks, and monthly thereafter to ensure compliance with TB skin tests 5. These systematic changes will be completed by 08/20/2016.</p>				

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

PRINTED: 08/24/2016  
FORM APPROVED  
OMB NO. 0938-0391

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