

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155822	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/17/2016
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NAME OF PROVIDER OR SUPPLIER CEDAR CREEK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 18275 BURR STREET LOWELL, IN 46356
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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: May 9, 10, 11, 12, 13, 16, and 17, 2016</p> <p>Facility number: 013144 Provider number: 155822 AIM number: 201246060</p> <p>Census bed type: SNF/NF: 8 SNF: 40 Residential: 32 Total: 80</p> <p>Census payor type: Medicare: 22 Medicaid: 8 Other: 18 Total: 48</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 5/19/16.</p>	F 0000	<p>This plan of correction is submitted by Cedar Creek Health Campus in order to the alleged deficiencies sited during the Annual Survey which was conducted on May 09, 2016. Preparation or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. Please accept this plan of correction as the credible allegation of compliance.</p>	
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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 0156 SS=A Bldg. 00	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of</p>			

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	<p>services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the</p>			

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	<p>physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review and interview, the facility failed to ensure Medicare Non-coverage letters were given in a timely manner for 1 of 3 residents reviewed for liability services of the 3 who met the criteria for liability services. (Resident #26)</p> <p>Finding includes:</p> <p>On 5/16/16 at 10:45 a.m. the Medicare Non-coverage letter for Resident #26 was reviewed. The letter indicated Medicare services would end on 2/2/16. The letter was signed by the resident's Power of Attorney on 2/1/16.</p> <p>Interview with the Social Service Director on 5/16/16 at 10:59 a.m. indicated the resident should have been given notice at least 48 hours prior to the end of Medicare services. She further indicated the notice had been given late.</p> <p>3.1-4(a)</p>	F 0156	<p>1. No ill effects to resident #26 due to family took resident home as planned. 2. Re-educated Social Service Director and Social Service Assistant on issuing the Non-coverage letters in a timely manner of 48 to 72 hours prior to discharge. 3. ED and or her designee will audit 3 cut letters per week to ensure timeliness of the notice. 4. Audits of cut letters will be brought to Quality Assurance to monthly x 3 months or until 100% compliance is obtained for any trends and make recommendations to the plan of correction as needed.</p>	06/16/2016

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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 pain care plan was developed for 1 of 5 residents reviewed for unnecessary medications. (Resident #50)</p> <p>Finding includes:</p> <p>The record for Resident #50 was reviewed on 5/11/16 at 10:43 a.m. The resident's diagnoses included, but were not limited to, osteoarthritis, chronic pain, diabetes mellitus and dementia. The resident was admitted to the facility on 2/3/16.</p>	F 0279	<p>1. Resident # 50 had no ill effects from not having pain care plan. A pain care plan was put into place on 5/11/16 for this resident. 2. An audit of current residents has been reviewed for completeness and updated if needed. 3. Interdisciplinary team and MDS coordinator will place a care plan for pain when completing an MDS.4. DHS or her designee will audit 5 residents receiving pain meds per week to ensure a pain plan of care is in place.5. Audit findings will be brought to Quality Assurance monthly x 3 months or until 100% compliance is obtained for any trends and make</p>	06/16/2016	

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	<p>Review of the Physician Order Summary for May 2016, indicated an order for acetaminophen (medication for pain) as needed and a morphine pump implanted in the lower left quadrant of the abdomen to dispense 8 mg (milligrams) three times a day.</p> <p>Review of the Medication Administration Record for May 2016, indicated acetaminophen was administered for back pain on 5/6/16.</p> <p>Review of the resident's record indicated the the morphine pump had been refilled on 4/18/16 at the hospital.</p> <p>Review of the 30 day Minimum Data Set assessment dated 3/2/16, indicated the resident was cognitively impaired and was on a scheduled pain medication regimen.</p> <p>The record lacked a current care plan for the resident's chronic pain.</p> <p>Interview with the Division Assessment Support on 5/12/16 at 12:01 p.m., indicated the resident should have had a care plan for pain.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>		<p>recommendations to the plan of correction as needed.</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 record review and interview, the facility failed to provide services in accordance with a resident's written plan of care related to not administering an anticoagulant medication as ordered by the resident's physician for 1 of 17 residents whose plan of care was reviewed. (Resident #11)</p> <p>Finding includes:</p> <p>Resident #11's record was reviewed on 5/12/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, type II diabetes mellitus, congestive heart failure, and atrial fibrillation.</p> <p>Resident #11 had a care plan for risk for decreased cardiac output related to diagnosis of atrial fibrillation. The</p>	F 0282	<p>1. Resident # 11 had no ill effects from missed doses of medication. Physician, family and resident notified of missed doses on 05/12/16. Lab was within normal limits.2. All current residents plans of care have been reviewed for compliance and undated to ensure accuracy.3. During Clinical Care Meeting daily all Coumadin orders will be checked to ensure INR results are entered into system and physician follow up completed.4. All nurses will be re-educated on how to put Coumadin orders in computer with emphasis on start and stop date and INR lab draw and ensuring all orders get followed thru. 5. DHS or her designee will audit 5 Coumadin orders per week to ensure all follow up is completed. These audits will be brought to Quality Assurance monthly x 6months or until 100%</p>	06/16/2016

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	<p>nursing interventions included "...Administer my cardiac medications per my MD orders..."</p> <p>Review of a Progress Note, dated 3/31/16 at 10:19 a.m. indicated "INR (international normalized ratio, a blood test to monitor blood coagulation) today = (equals) 2.6. NO (new order) obtained from (nurse practitioner's name) to continue Coumadin (warfarin, a blood thinning medication) 4 mg qD (every day) with an in house recheck INR on 4/4/16."</p> <p>Review of the 4/2016 MAR indicated the resident did not receive any Coumadin medication on 4/1/16, 4/2/16, 4/3/16, and 4/4/16. The MAR indicated the INR test had been completed on 4/4/16 and the result was 1.9. The same dose of Coumadin was to be continued and the next INR test was to be done 4/8/16.</p> <p>Interview with the DHS on 5/12/16 at 3:10 p.m. indicated the resident had missed the four doses of Coumadin. She further indicated the nurse who had been working had recorded the INR result on 3/31/16 but did not put in the order for the Coumadin medication. She indicated the resident's INR was within normal limits during this time, she would notify the physician and family of the</p>		<p>compliance is obtained for any trends and make recommendations to the plan of correction as needed.</p>				

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F 0309 SS=D Bldg. 00	<p>medication error, and re-educate the nurses.</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 record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to follow up of a Hospice order for blood sugar testing for 1 of 1 residents reviewed for Hospice Care. (Resident #42)</p> <p>Finding includes:</p> <p>Record review for Resident #42 was completed on 5/13/16 at 1:21 p.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, Alzheimer's Disease, heart failure, anxiety and depression.</p> <p>Review of the resident's Hospice Plan of Care indicated the resident started</p>	F 0309	<p>1. Resident # 42 had no noted ill effects at this time.2. Current residents receiving hospice was checked to ensure all orders from those services are reflective on our order sheets.3. DHS did re-educate with current hospice service about the need to report off to the Cedar Creek nurse before leaving to ensure better communication or orders and care. 4. DHS or designee will audit 3 residents on hospice weekly to ensure all orders are carried through to our order set.5. DHS or her designee will bring audit findings to Quality Assurance monthly x 3 months or until 100% compliance is obtained for any trends and make recommendations to the plan of correction if needed.</p>	06/16/2016

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	<p>Hospice on 9/18/15 with a diagnosis of End Stage Alzheimer's Disease.</p> <p>Review of the May 2016 Physician Order Summary indicated the resident received pioglitazone (diabetic medication) 15 mg (milligrams) every day.</p> <p>A Nursing Note dated 3/17/16 indicated the Hospice nurse was in the facility with a new order to check the resident's blood sugar if the resident appeared lethargic or if the resident's son requested.</p> <p>Review of Physician Orders from 3/17/16 to current lacked an order to check the resident's blood sugars when necessary.</p> <p>Interview with the DHS (Director of Health Services) on 5/16/16 at 3:43 p.m., indicated the staff should have followed up on the order with Hospice and the resident's physician regarding the blood sugar testing. She indicated the nurse had not followed up on the order because she had assumed Hospice had put the order in. She further indicated there was a need for better communication between the facility and Hospice.</p> <p>3.1-37(a)</p>			

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F 0325 SS=D Bldg. 00	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on record review and interview, the facility failed to ensure a resident with a significant weight loss had a reweigh completed as ordered by the RD (Registered Dietician) and failed to notify the RD the resident's wound had deteriorated for 1 of 3 residents reviewed for nutrition of the 8 who met the criteria for nutrition. (Resident # 64).</p> <p>Findings include:</p> <p>Record review for Resident #64 was completed on 5/11/16 at 9:18 a.m. The resident's diagnoses included, but were not limited to, heart failure, hypertension, diabetes mellitus and Alzheimer's Disease.</p> <p>Review of the resident's weight record indicated the resident weighed 172 lbs.</p>	F 0325	<p>1. Resident # 64 has no ill effects noted at this time. Weight is stable Diabetic ulcer is healing.</p> <p>2. All like residents have been audited to ensure no weight difference of 5% or more will be evaluated for appropriate follow up.</p> <p>3. All nursing staff re-educated on guidelines for weight tracking. Any weight that seems out of the normal range will have a re-weight. Physician and dietitian will be notified. Dietitian will meet weekly With DHS and or her designee to ensure all notifications in weights or skin is addressed.</p> <p>4. DHS or designee will audit 5 residents per week for weight or skin changes and check for follow up of appropriate notification. DHS or her designee will bring audit findings to Quality Assurance monthly x 6 months to til 100% compliance is obtained and for any trends and make</p>	06/16/2016	

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	<p>(pounds) on 4/5/16. The resident's weight was 160 lbs. on 5/2/16. This was a 12 lb. significant weight loss in 30 days.</p> <p>Review of Nursing Notes from 5/2/16 to 5/11/16 lacked any indication the 12 lb. weight loss had been addressed or the RD had been notified.</p> <p>Review of a Nutrition Care Plan indicated the resident would like to meet nutritional and hydration needs to support overall metabolic demands and had an increased need for protein to support wound healing. An intervention included to obtain weights as ordered and needed.</p> <p>A Pressure Wound Event dated 3/9/16 indicated the resident had a stage 2 pressure ulcer to the left heel measuring 3 cm (centimeters) x 5.8 cm. The wound treatment order was to apply sure prep (skin protecting wipe) to the area and leave open to air every shift.</p> <p>A dietary assessment note completed by the RD on 3/10/16 at 3:52 p.m., indicated she had discussed with the wound nurse regarding the area to the left heel. She indicated to continue diet as ordered and the resident's current intakes plus diet were within the estimated protein needs to support healing.</p>		<p>recommendations to the plan of correction as needed.</p>	

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	<p>A Pressure Wound Event dated 3/23/16 indicated the resident's wound had deteriorated. The wound was now an unstageable pressure ulcer measuring 4.3 cm x 6.2 cm x undetermined. The wound had slough (non-viable tissue).</p> <p>A Physician's Order dated 3/23/16 was to change the wound treatment from sure prep to santyl (debriding ointment) everyday.</p> <p>A Physician Note dated 3/26/16 at 3:17 p.m., indicated the resident had a stage 3 pressure wound to the left heel. The resident's heel was red and inflamed. The action plan was to continue the santyl treatment and start Bactrim DS (antibiotic) twice a day for 10 days.</p> <p>A Pressure Wound Event dated 4/6/16 indicated the wound to the left heel had not improved and had increased in size. The wound was unstageable measuring 5.8 cm x 6.4 cm x undetermined with slough. The wound had moderate purulent (containing pus) drainage with a foul odor.</p> <p>A Nursing Note completed on 4/9/16 at 1:39 p.m., indicated a new order received from the doctor for sugar free ProMod (liquid protein) 30 mls (milliliters) every</p>			

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	<p>day.</p> <p>A Physician Note completed on 4/9/16 at 4:09 p.m., indicated the resident's left heel wound was not responding to treatment. The resident was scheduled for the wound clinic and just finished a round of antibiotics.</p> <p>A monthly follow up nutrition assessment note completed by the RD on 4/21/16 indicated the pressure area to left heel was persistent, but showing improvement (wound had, in fact, started at stage 2 and now was unstageable). An intervention included to continue the ProMod as ordered to support wound healing.</p> <p>The record indicated the RD did a nutritional assessment on the resident on 3/10/16 and did not do another nutritional assessment until 4/21/16 which was 6 weeks later. The record lacked any indication the RD had been notified the resident's wound had deteriorated.</p> <p>Interview with the RD on 5/12/16 at 11:30 a.m., indicated she would do a monthly nutritional assessment on a resident with wounds. She indicated she comes to the facility on a weekly basis and speaks with the wound nurse. She indicated she was unaware the resident's</p>			

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	<p>wound had deteriorated and staff should have informed her so she could have done another nutritional assessment on the resident. She further indicated she was aware the resident had a significant weight loss. She indicated she had requested a reweigh to be completed on the resident. She further indicated when she had come back into the facility today, a week later, the reweigh had not been completed, so she requested the reweigh again today.</p> <p>Interview with the Assisted Living Manager/Wound Nurse on 5/12/16 at 11:37 a.m., indicated she would speak with the RD on a weekly basis regarding the resident's wound status. She indicated she was unaware if she had told the RD whether or not the resident's wound had deteriorated. She indicated the RD should have been informed. She further indicated, according to the wound clinic notes, the resident did not have a pressure ulcer to the left heel. The wound was a diabetic ulcer.</p> <p>A follow up interview with the RD on 5/12/16 at 3:32 p.m., indicated the resident was re-weighed and his weight was 166.4. She further indicated this was not a significant weight loss.</p> <p>Interview with the DHS (Director of</p>			

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F 0329 SS=D Bldg. 00	<p>Health Services) on 5/16/16 at 1:50 p.m., indicated she had received documentation from the wound clinic that the wound was a diabetic ulcer and not a pressure ulcer as they had first thought.</p> <p>A policy titled, "Guidelines For Weight Tracking", was received as current from the ADHS (Assistant Director of Health Services) on 5/17/16 at 9:55 a.m. The policy indicated, "...Procedure: 7. Residents who have a weight that seem out of normal range shall be re-weighed to determine the accuracy of the original weight. This should be completed when the discrepancy is noted and not wait until the dietician recommends a re-weigh...."</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>			

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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted and documented prior to the administration of pain medication, anticoagulant medication was administered as ordered, and an AIMS (Abnormal Involuntary Movement Scale) assessment was completed for residents receiving an antipsychotic medication for 3 of 5 residents reviewed for unnecessary medications. (Residents #11, #42, and #50)</p> <p>Findings include:</p> <p>1. Resident #11's record was reviewed on 5/12/16 at 9:00 a.m. The resident's diagnoses included, but were not limited to, type II diabetes mellitus, congestive heart failure, and atrial fibrillation.</p> <p>Review of the 5/2016 Physician's Order</p>	F 0329	<p>1. Resident # 11, 42 and 50 had no ill effects noted at this time.2. Current residents will be assessed and a AIMS completed to receive a baseline. Those who trigger will have an AIMS completed quarterly3. All nursing staff have been re-educated on the interventions to be tried before the administration of pain meds. All nurses re-educated on completing an AIMS on admission to get a baseline. All nurses re-educated on anticoagulant medication administration. 4. DHS or her designee will audit 3 residents per week for interventions prior to giving meds and 3 residents per week on baseline AIMS being completed and if warranted updates quarterly for AIMS. DHS and or her designee will audit 3 residents per week on anticoagulant medication administration. 5. DHS will bring audit findings to Quality Assurance monthly x 3 months review until 100% compliance is</p>	06/16/2016

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	<p>Summary, indicated an order for tramadol (Ultram, a narcotic pain medication) 50 milligrams (mg) every 6 hours as needed and acetaminophen (Tylenol, a pain medication) 650 mg every 4 hours as needed for pain.</p> <p>Review of the 5/2016 Medication Administration Record (MAR) indicated there were no non-pharmacological interventions attempted prior to the administration of the tramadol medication on the following dates and times:</p> <ul style="list-style-type: none"> -5/1/16 11:58 a.m. and 11:22 p.m. -5/2/16 5:21 a.m. and 11:15 a.m. -5/3/16 6:31 pm -5/4/16 11:09 p.m. -5/6/16 6:05 p.m. -5/8/16 1:03 p.m. -5/11/16 5:31 a.m. <p>Review of the 4/2016 and 5/2016 Medication Administration Records (MARs) indicated there were no non-pharmacological interventions attempted prior to the administration of the acetaminophen medication on the following dates and times:</p> <ul style="list-style-type: none"> -4/5/16 8:47 a.m. -4/7/16 2:38 a.m. -4/9/16 2:12 a.m. -4/13/16 12:11 p.m. -4/20/16 8:38 a.m. 		obtained and for any trends make recommendations to the plan of correction as needed.				

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	<p>-4/28/16 9:00 a.m., 2:54 p.m., and 9:47 p.m. -4/29/16 11:26 p.m., 5:57 a.m. -5/5/16 7:52 a.m.</p> <p>Review of a Progress Note, dated 3/31/16 at 10:19 a.m. indicated "INR (international normalized ratio, a blood test to monitor blood coagulation) today = (equals) 2.6. NO (new order) obtained from (nurse practitioner's name) to continue Coumadin (warfarin, a blood thinning medication) 4 mg qD (every day) with an in house recheck INR on 4/4/16."</p> <p>Review of the 4/2016 MAR indicated the resident did not receive any Coumadin medication on 4/1/16, 4/2/16, 4/3/16, and 4/4/16. The MAR indicated the INR test had been completed on 4/4/16 and the result was 1.9. The same dose of Coumadin was to be continued and the next INR test was to be done 4/8/16.</p> <p>Interview with the Director of Health Services (DHS) on 5/12/16 at 10:52 a.m. indicated interventions should have been attempted prior to the administration of the PRN (as needed) pain medications. She further indicated the interventions should have been documented on the MAR.</p>						

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	<p>Interview with the DHS on 5/12/16 at 3:10 p.m. indicated the resident had missed the four doses of Coumadin. She further indicated the nurse who had been working had recorded the INR result on 3/31/16 but did not put in the order for the Coumadin medication. She indicated the resident's INR was within normal limits during this time, she would notify the physician and family of the medication error, and re-educate the nurses.</p> <p>2. Record review for Resident #42 was completed on 5/13/16 at 1:21 p.m. The resident's diagnoses included, but were not limited to, dementia, diabetes mellitus, Alzheimer's Disease, heart failure, anxiety and depression.</p> <p>The Annual MDS (Minimum Data Set) assessment completed on 3/25/16 indicated the resident was severely cognitively impaired. The assessment indicated the resident had received an antipsychotic medication.</p> <p>Review of a Care Plan indicated the resident was at risk for adverse consequences related to receiving antipsychotic medication for the treatment of dementia with behaviors. An intervention included to do an AIMS (Abnormal Involuntary Movement Scale)</p>			
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	<p>assessment every quarter.</p> <p>Review of the May 2015 Physician Order Summary indicated the resident received Risperdal (medication to treat psychotic conditions) 0.5 mg (milligrams) twice a day.</p> <p>Review of the resident's record lacked a completed AIMS assessment since 9/17/15.</p> <p>Interview with the DHS (Director of Health Services) on 5/6/16 at 11:46 a.m., indicated an AIMS assessment had not been completed on the resident since the previous one in September 2015. She further indicated an AIMS assessment should have been completed since then.</p> <p>3. The record for Resident #50 was reviewed on 5/11/16 at 10:43 a.m. The resident's diagnoses included, but were not limited to, osteoarthritis, chronic pain, diabetes mellitus and dementia. The resident was admitted to the facility on 2/3/16.</p> <p>Review of the Physician Order Summary for May 2016, indicated risperidone (antipsychotic medication) 2.5 mg (milligrams) twice a day.</p> <p>Review of the Medication Administration Record for May 2016 indicated the</p>			

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F 0406 SS=D Bldg. 00	<p>medication risperidone was given as ordered.</p> <p>The record lacked indication an AIMS (Abnormal Involuntary Movement Scale) assessment had been completed.</p> <p>Interview with the Assistant Director of Health Services on 5/12/16 at 12:09 p.m., indicated an AIMS assessment should have been completed upon admission and quarterly by the nurses and had been missed.</p> <p>3.1-48(a)(6)</p> <p>483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must</p>			

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	<p>provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on record review and interview, the facility failed to ensure a resident who required a yearly review from the Pre-Admission Screening Level Two assessment received one in a timely manner for 1 of 1 residents reviewed for Pre-Admission Screening of the 2 residents who met the criteria for Pre-Admission Screening. (Resident #15)</p> <p>Finding includes:</p> <p>The record for Resident #15 was reviewed on 5/11/16 at 1:03 p.m. The resident's diagnoses included, but were not limited to, depression, anxiety and diabetes mellitus.</p> <p>The 5 Day Minimum Data Set assessment dated 11/23/15 indicated the resident had a diagnosis of depression.</p> <p>Review of the Pre-Admission screening Level Two assessment, dated 9/19/14, indicated the resident was mentally ill with depression and required a yearly review. The form indicated the next case review would be in 2015.</p>	F 0406	<p>1. Resident #15 had no ill effects at this time. Level II has been scheduled for this resident 2. Audits of all level 2 have been completed.3. New SSD and SSA have been re-educated on the Level II process and on keeping a spreadsheet so they can be scheduled timely.4. ED or her designee will audit 3 residents on Level II list weekly to ensure the Resident Reviews have been scheduled timely for services. 5. ED or her designee will bring audit findings to Quality Assurance monthly x 3 months until 100% compliance is obtained for any trends and make recommendations to the plan of correction as needed.</p>	06/16/2016			

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F 0441 SS=E Bldg. 00	<p>Interview with the DHS (Director of Health Services) on 5/12/16 at 11:25 a.m., indicated the resident had not had the yearly review completed. She indicated the resident should have had one completed in 9/2015.</p> <p>3.1-23(a)(2)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p>			

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	<p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to ensure an infection control program was maintained related to TB (Tuberculosis) testing not completed for 3 of 5 residents reviewed for TB testing. The facility also failed to ensure a lancet (small pointed knife that is used to prick a finger for a blood test) and a glucometer test strip (test strip to test blood sugar) was disposed of properly during a medication administration observation. (Resident #38, Resident #68, Resident #71 and Resident #92)</p> <p>Findings include:</p> <p>1. Record review for Resident #38 was completed on 5/16/16 at 2:31 p.m. The</p>	F 0441	<p>1. No ill effects noted to resident #38, 68, 71, 92. Residents #38, 68, 71, 92 have all received their mantoux testing. 2. All new residents have been audited to ensure all step I and Step II mantoux have been completed and if not they will be set up. 3. All licensed staff will be re-educated on TB testing guidelines for residents and on the guidelines for accurchecks with emphasis on disposal of lancets and test strips. 4. DHS or her designee will observe 3 nurses weekly on different shifts on disposal of accurcheck supplies. DHS or her designee will audit 5 new residents per week to ensure all mantoux are completed as ordered. 5. DHS or her designee will bring audit findings to Quality Assurance</p>	06/16/2016	

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	<p>April 2016 MAR (Medication Administration Record) indicated the resident was administered an annual TB test on April 11, 2016. The MAR lacked any indication the test results had been read.</p> <p>2. Record review for Resident #68 was completed on 5/16/16 at 2:50 p.m. The resident was admitted to the facility July 2015. The record lacked any indication TB testing had been completed on the resident after admission to the facility.</p> <p>3. Record review for Resident #71 was completed on 5/16/16 at 2:55 p.m. The resident was admitted to the facility November 2015. The record lacked any indication TB testing had been completed on the resident after admission to the facility.</p> <p>Interview with the Medical Records Nurse on 5/16/16 at 2:45 p.m., indicated Resident #38 did have an annual TB test completed in April 2016 but their was no documentation to indicate the test results had been read.</p> <p>Interview with the ADHS (Assistant Director of Health Services) on 5/16/16 at 3:15 p.m., indicated Resident #68 had left the facility and went to another facility for 2 months then was readmitted</p>		monthly x 6 months until 100% compliance is obtained and make recommendations to the plan of correction as needed.	

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	<p>to the facility July 2015. She indicated they did not do a TB test on the resident when he was readmitted back to the facility in July. She further indicated a TB test was not completed on Resident #71 after he was admitted to the facility November 2015.</p> <p>A policy titled, "Guidelines for TB Results Summary Documentation: Residents", was received as current from the Administrator in Training on 5/17/16 at 9:41 a.m. The policy indicated, "...Procedures 1. Upon admission each resident shall receive a Two Step Mantoux PPD test to ensure they are free of tuberculosis..." "...9. Document results of annual evaluation on the TB Results Summary in the resident's medical record..."</p> <p>4. During an observation of an accucheck (a diabetic blood sugar test) with Resident # 92 and LPN #8 on 5/11/16 at 11:08 a.m., the following was observed:</p> <p>After LPN #8 performed the accucheck, the lancet and the blood filled test strip was discarded into the medication cart's trash bin.</p> <p>Interview with LPN #8 on 5/11/16 at 11:36 a.m., indicated the lancet and the used test strip should have been thrown</p>			

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R 0000 Bldg. 00	<p>away in the sharps container and not the trash bin.</p> <p>A facility policy titled, "Guidelines for Accuchecks" was provided by the Nurse Consultant on 5/11/16 at 11:52 a.m., and was identified as the current policy used by the facility. The policy indicated, "...4. Testing supplies shall be properly disposed of in biohazard containers...."</p> <p>3.1-18(b)(2) 3.1-18(e) 3.1-18(f)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 32</p> <p>Residential Sample: 7</p>	R 0000	<p>This plan of correction is submitted by Cedar Creek Health Campus in order to the alleged deficiencies sited during the Annual Survey which was conducted on May 09, 2016. Preparation or execution of this plan of correction does not constitute admission or</p>	

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R 0002 Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 32883 on 5/19/16.</p> <p>410 IAC 16.2-5-0.5(b) Scope of Residential Care - Offense (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule.</p> <p>Based on record review and interview, the facility failed to ensure contracted services were arranged in a timely manner related to wound care for 1 of 1 residents reviewed for wounds in the sample of 7. (Resident #3)</p> <p>Finding includes:</p> <p>The record for Resident #3 was reviewed on 5/16/16 at 9:15 a.m. The resident's diagnoses included, but were not limited to, dementia without behavior disturbance, diabetes, depressive disorder and anxiety disorder. The resident was admitted to the facility on 2/19/16.</p> <p>An entry in the Nursing Progress notes dated 3/21/16 at 10:13 p.m., indicated two open areas were observed on the resident's buttocks. The first area was on the coccyx and approximately 1 centimeter (cm) circular and 1 cm deep.</p>	R 0002	<p>agreement by provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. Please accept this plan of correction as the credible allegation of compliance.</p> <p>1. Resident # 3 has been moved to the healthcare side until area is resolved. Resident then will be re-evaluated for Assisted living. 2. Current orders for home health service needs on Assisted living have been evaluated to ensure all services have been acquired in a timely manner. No other issues noted. 3. Nursing staff have been re-educated on ensuring home health services are carried out in a timely manner per physician orders. During clinical care meeting 5 x per week DHS or her designee will audit 5 physician orders per week for follow thru of any home health orders. 4. DHS or her designee will bring audits to Quality Assurance Meeting monthly x 3 months or until 100% compliance is obtained. Q&A will review monthly and make recommendations as needed for the POC.</p>	06/16/2016

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	<p>The second area was below the sacrum and approximately 3 cm long, 2 cm wide and 1 cm deep.</p> <p>A Physician's order dated 3/23/16, indicated a treatment to the mid coccyx was to be completed daily and as needed for soilage and/or dislodgement. The treatment was as follows: Cleanse area to mid coccyx with normal saline or wound wash, pat dry, pack wound with slightly moistened saline gauze, apply sure prep to peri wound and cover with dry dressing.</p> <p>Review of the March 2016 Treatment Administration Record (TAR), indicated the treatment was signed out by facility staff on 3/24/16-3/31/16.</p> <p>A Physician's order dated 3/29/16, indicated Home Health Services were to provide wound care services.</p> <p>The resident was seen by Home Health on 3/30/16. The wound was described as an "old pilonidal cyst surgical site." The wound measured 3 cm x 2 cm x 2.5 cm. The wound was cleansed with saline, loosely packed with a saline soaked 4 x 4 and covered with a dry 4 x 4 and bordered gauze. Orders were received for Home Health to complete the treatment three times a week on Monday,</p>			

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R 0120 Bldg. 00	<p>Wednesday, and Friday and as needed.</p> <p>Interview with the Assisted Living Manager on 5/17/16 at 12:45 p.m., indicated the resident's Responsible Party was contacted on 3/23/16. The resident's Responsible Party responded to the Assisted Living Manager on 3/24/16 to set up services for wound care. The Assisted Living Manager indicated Home Health was not contacted until 3/29/16 and licensed staff at the facility were completing the treatment.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with</p>			
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	<p>residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.</p> <p>(3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure eight hours of the required nursing personnel annual inservices were completed for 12 of 12 licensed staff members reviewed. (LPN #2, LPN #3, LPN #4, LPN #5, LPN #6, CRCA #1, CRCA #2, CRCA #3, CRCA #4, CRCA #5, CRCA #6, and CRCA #7)</p> <p>Finding includes:</p> <p>Review of the facility inservices on 5/17/16 at 9:00 a.m., indicated LPN #2, LPN #3, LPN #4, LPN #5, LPN #6, CRCA #1, CRCA #2, CRCA #3, CRCA #4, CRCA #5, CRCA #6, and CRCA #7, who worked in the facility during the 2015 calendar year, had not received the required 8 hours of annual inservices for the 2015 calendar year.</p>	R 0120	<p>1. The staff scheduled on Assisted Living have all completed their in-services for the first half of the year. No adverse effects noted from 2015 in-servicing issues.2. All Assisted Living staff will have their inservices completed in a timely, time frame to ensure compliance with State regulations and requirements by end of 2016. 3. Inservice completion audit will be completed weekly on 5 employees by staff development with the audit given to ED or her designee for follow up to ensure compliance with nursing personal inservices monthly.4. Staff development will bring audits to Quality Assurance to ensure compliance monthly x3 months or until 100% complainance is obtained for any trends and make recommendations to the plan of correction if needed.</p>	06/16/2016	

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R 0217 Bldg. 00	<p>Interview with the Executive Director on 5/17/16 at 9:32 a.m., indicated the required annual inservices had not been completed for 2015 as they should have.</p> <p>410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on record review and interview, the facility failed to ensure the Service</p>	R 0217	1. Residents #2 was a discharged residents no known ill effects	06/16/2016

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	<p>Plan was signed by the resident and/or their responsible party for 7 of 7 records reviewed. (Residents #2, #3, #4, #5, #6, #7, and #8)</p> <p>Findings include:</p> <ol style="list-style-type: none"> The closed record for Resident #2 was reviewed on 5/16/16 at 2:25 p.m. The resident was admitted to the facility on 11/14/15. The Service Plan for November 2015 was signed by the Nurse but not by the resident. The record for Resident #3 was reviewed on 5/16/16 at 9:15 a.m. The resident was admitted to the facility on 2/19/16. The Service Plan dated 2/19/16 was not signed by the resident and/or his Responsible Party. The record for Resident #4 was reviewed on 5/16/16 at 10:00 a.m. The resident was readmitted to the facility on 10/14/15. The resident had Service Plans dated 10/15/15, 11/23/15, 12/21/15, 1/15/16, 2/15/16 and 5/3/16. None of the Service Plans had been signed by the resident. The record for Resident #5 was reviewed on 5/16/16 at 10:45 a.m. The resident was admitted to the facility on 10/9/15. The resident had Service Plans 		<p>noted. Residents #3,4,5,6,7,8 have all had their service plans updated and signed by resident or family member.2. Current service plans have been updated and unit manager or her designee have gone over with resident and/or family and obtained signature on service plan. 3. Nursing admit team inserviced on requirements of needing service plans signed every 6 months. 4. DHS or her designee will audit 5 service plans a week to ensure resident or family have signed.5. Audits will be brought to Quality Assurance monthly x 3 months or until 100% compliance is obtained for any trends and make recommendations to the plan of correction as needed.</p>	

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	<p>dated 10/9/15, 11/23/15, 12/21/15 and 3/14/16. The Service Plans had been signed by the Nurse but not by the resident and/or their Responsible Party.</p> <p>5. The record for Resident #6 was reviewed on 5/16/16 at 12:50 p.m. The resident had Service Plans dated 1/15/16 and 2/15/16. The Service Plans were signed by the Nurse but not by the resident.</p> <p>6. The record for Resident #7 was reviewed on 5/16/16 at 1:25 p.m. The resident had Service Plans dated 3/15/16 and 5/3/16. The Service Plans were signed by the Nurse but not by the resident.</p> <p>7. The closed record for Resident #8 was reviewed on 5/6/16 at 1:15 p.m. The resident had Service Plans dated 10/15/15 and 11/24/15. The Service Plans had been signed by the Nurse but not by the resident and/or their Responsible Party.</p> <p>Interview with the Assisted Living Manager on 5/17/16 at 1:30 p.m., indicated all of the above Service Plans had not been signed by the residents and/or their Responsible Parties.</p>			