

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/23/2013
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NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 11610 TECHNOLOGY DR CARMEL, IN 46032
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R000000	<p>This visit was for the State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00137809.</p> <p>Complaint IN00137809-Substantiated . State deficiencies related to the allegations are cited at R 0052, R 117, R 144, R 214, R 217.</p> <p>Survey dates : October 21, 22, and 23, 2013.</p> <p>Facility number : 012309 Provider number : 012309 AIM number : N/A</p> <p>Survey team : Michelle Hosteter, RN-TC Gloria Bond, RN</p> <p>Census bed type: Residential : 34</p> <p>Census payor type: Medicaid : 23 Other : 11 Total : 34</p> <p>Sample : 8</p> <p>These state findings are cited in</p>	R000000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</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>accordance with 410 IAC 16.2</p> <p>Quality Review was completed by Tammy Alley RN on November 1, 2013.</p>						

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R000052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview the facility failed to ensure a resident was not subject to neglect for 1 of 3 residents reviewed for neglect. (Resident B)</p> <p>Findings include:</p> <p>The record review for Resident B was completed on 10/21/13 at 1:45 P.M. Diagnoses included, but were not limited to diabetes, ruptured aneurysm, high blood pressure, neuropathy, and depression.</p> <p>The nurses notes indicated, "...10/7/13 8:30 p.m. Resident was lying in apartment when a employee was checking on her, she came to tell QMA #4 she was on the floor V/S [vital signs] 140/70, 98.6, 72, 22. 8:45- She stated she did not hit head her arm was hurting. she did not request a pain pill. 8:50 - I called 911 to assist her off the floor she did not want to go to the hospital. 9:20 -Physician, family, and Director of</p>	R000052	<p>1. Resident B was affected. Staff followed the facility policy on abuse prohibition. The Administrator was notified immediately, QMA #4 was immediately suspended, and investigation was initiated. The employee was terminated. The incident was reported to ISDH per facility policy. 2. All residents have the potential to be affected. All staff were in-serviced on the facility's abuse prohibition policy, (please see attachment A). 3. As a measure of ongoing compliance, the DON or designee will interview 5 residents monthly regarding their care and staff interaction ongoing. Should a deficient practice be noted, immediate corrective action will be taken, (please see attachment B). 4. As a measure of quality assurance, the Administrator or designee will monitor and sign off on the monthly audit ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>	11/11/2013			

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	<p>Nursing [DON] notified. 9:35 -Resident refused to go to hospital stated her family will take her. 10/8/13-3:30 p.m. Found resident in room in doggie style position in front of couch. Resident was trying to smoke electronic cigarette. Resident refused to have blood sugar taken and has no complaints of pain doctor and DON notified...."</p> <p>A reportable to the Indiana State Department of Health of unusual occurrences was provided by the administrator 10/23/13 at 10 A.M. The investigation was dated 10/8/13, with the incident date of 10/7/13 9:00 P.M. The brief description of the incident indicated, "...At approximately 9:00 pm QMA #5 came into Resident B's room. She stated she found her on the floor. She immediately went to get QMA #4 who was the QMA working at the time. 911 was called to get her up and into her bed. At 9:30 am on 10/8/13 Resident B reported to the DON that QMA #4 had called her names and used profanity while talking to her during the incident pertaining to the fall the night before...QMA #4 was immediately suspended pending investigation. An investigation was initiated...."</p>			

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	<p>A witness statement with no time and date by QMA #5 indicated, "...I QMA #5 came to work at 8:30 p.m. Upon arrival I went to Resident B's room to borrow charger for phone. Found resident laying on floor in a puddle of water that was saturating into carpet. Resident stated she had fallen [sic] getting out of shower and needed help...Words were exchanged between resident/staff however no profanity was involved. The Fire Dept arrived and assisted Resident B off floor onto bed...."</p> <p>A witness statement with no time and date by QMA #4 indicated, "...QMA #5 was in Resident B's room. She came and got me and told me Resident B was on the floor. Resident B's floor was covered with water, dog food and clothes. She was laying in the bathroom floor. I asked her if she hit her head and she said no. I called 911 and fire department asked her if she wanted to go to the hospital and she said "no". They picked her up and put her in the bed. I moved wet clothes out of the way for fire department to get in Resident B's room. I cleaned up most of the dog food out of the bathroom...."</p> <p>A witness statement with no time and</p>			

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	<p>date by QMA #6 indicated, "...At about 20 till 7:00 I went into Resident B's room and the floor was soaking wet. Resident B told me she flooded the place. She took a shower and QMA #4 left me on the floor...Later myself and QMA #3 and QMA #7 cleaned up the room...."</p> <p>A witness statement dated 10/8/13 by QMA #3 indicated, "...A little after 6:00 am QMA #5 was in the nurse's station filling out paperwork for Resident B. QMA #5 told me Resident B fell twice. The night before she came in early...she found Resident B on the floor. The second time Resident B fell another resident came and got her saying someone is yelling and I think she fell. At 10:30 am I went to her room and noticed the carpet and the bathroom floor was soaked...."</p> <p>In an interview with Resident B on 10/22/13 at 1:00 p.m., she indicated she had lived here since August and feels the staff had not taken good care of her as she almost died when her blood sugar got so low because no one woke her up for the meal that evening. She indicated she fell one night after getting out of the shower and she was left her lying on the floor for 5 hours and she had to yell for</p>						

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	<p>help and finally someone came.</p> <p>The Executive Director on 10/23/13 at 1:30 p.m., indicated she knew that there was a problem with what happened with Resident B and that is why they terminated QMA # 4.</p> <p>This Residential tag relates to the Complaint # IN00137809.</p>						

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R000117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility did not have adequate First Aid and Cardio Pulmonary Resuscitation (CPR) trained staff to cover all shifts. This deficient practice had the potential to affect 34 of 34 residents residing in the building.</p> <p>Findings include :</p> <p>1. The employee records were</p>	R000117	<p>1. No residents were harmed. 2. All residents have the potential to be affected. All nursing staff have received education for First Aid and Cardio Pulmonary Resuscitation (CPR) certification and are now certified. 3. As a measure of ongoing compliance the DON or designee will complete an audit, (Please see attachment C) monthly to ensure all staff nursing have current First Aid and CPR certifications. Anyone found to require</p>	11/11/2013			

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	<p>reviewed on 10/23/13. The records indicated they had 4 out of 13 regularly scheduled employees trained in CPR and First Aid.</p> <p>The employee schedule as worked for September and October 2013 was reviewed. The schedule indicated there were no days for either month where there was CPR and First Aid trained staff working each 8 hour assigned shift.</p> <p>In an interview with the Executive Director on 10/23/13 at 2:00 p.m., she indicated she was in the process of signing up more staff for First Aid and CPR training.</p> <p>This Residential tag relates to the Complaint # IN00137809.</p>		<p>re-certification for First Aid and/or CPR will be required to complete the re-certification class and obtain current certification before returning to work. 4. As a measure of quality assurance the Administrator or designee will sign off on the monthly audit ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>				

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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the resident rooms and the general environment was clean and repairs completed. This deficit practice had the potential to affect 34 of 34 residents residing in the building.</p> <p>Findings include:</p> <p>In an observation of Room 406 on 10/22/13 at 1:00 p.m., the floor had scattered paper debris, dog food, wrappers, and stains on the carpet.</p> <p>In an observation of Room 402 on 10/21/13 at 11:00 a.m., there was staining noted on the carpet.</p> <p>In an observation of Room 108 on 10/21/13 at 10:00 a.m., there was staining noted on the carpet.</p> <p>During the environmental tour with the Executive Director (ED) on 10/23/13 at 11:00 a.m., the 400 hallway resident rooms 402 and 406 were noted to have several marks and scratches with missing paint on the entry way doors. The activity room</p>	R000144	<p>1. Room 403 was cleaned. The carpet in rooms 402 and 108 have been cleaned. The entryway doors for rooms 402 and 406 were repaired and painted. The activity room entry walls were repaired and painted. The ceiling in the hall by the beauty salon, time clock, and 300 hall way was repaired and painted. 2. All residents have the potential to be affected. The Administrator completed facility rounds to ensure all needed repairs were addressed. 3. As a measure of ongoing compliance the Administrator or designee will review any work orders received daily on regularly scheduled days ongoing to ensure repairs are completed. Additionally, the now employed Maintenance Director or designee will complete facility rounds, (please see attachment D) on a weekly basis ongoing to note any needed repairs. Any repairs needed will be addressed timely. 4. As a measure of quality assurance the Administrator or designee will sign off on the weekly audit ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>	11/11/2013			

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	<p>entryway walls had scratching and missing paint on them. The ceiling in the hallway by the beauty salon, time clock and the 300 hallway had water stains and drywall and spackling noted on the ceiling. The ED indicated at this time that they had hired contractors to come in and work on a pipe that had burst and that they were following up to finish the repairs.</p> <p>In an interview with the ED on 10/22/13 at 1:30 p.m., she indicated they had no current maintenance person as of 10/1/13. She stated she did not have any records of work orders for any repairs.</p> <p>A document provided by the Executive Director on 10/23/13 at 11:28 a.m., indicated the contractors had been in on 2/22/13 to replace a water line and cover hole in dry wall. The ED indicated she had no further information to provide as to when the area was to be painted and the new leak area covered.</p> <p>This Residential tag relates to the Complaint # IN00137809.</p>						

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R000148	<p>410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows:</p> <p>(1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected.</p> <p>Based on observation and interview, the facility did not provide a safe environment for a resident at risk for falls for 1 of 1 rooms observed for safety hazards. (Resident B)</p> <p>Findings include:</p> <p>Resident B had a fall on 10/7/13. In an observation of Resident B's room on 10/22/13 at 1:00 p.m., her emergency pull cord in her main living area was blocked by a desk with several personal items on it. The cord was behind the back of the desk and unable to be reached.</p>	R000148	<p>1. Resident B was affected. Resident B's room was arranged so that the emergency pull cord was easily accessible. 2. All residents have the potential to be affected. All resident apartments were checked to ensure the emergency cords were easily accessible. All nursing staff have been in-serviced on the emergency pull cords being easily accessible, (please see attachment J). 3. As a measure of ongoing compliance the DON or designee will check all resident apartments monthly ongoing to ensure the emergency pull cords are easily accessible, (please see attachment E). 4. As a measure of quality assurance the</p>	11/11/2013			

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	<p>During the environmental tour with the Executive Director on 10/23/13 at 11:10 a.m., the emergency pull cord was unable to be reached by the resident in it's current location.</p> <p>In an interview with the Executive Director at that time she indicated they would have to rearrange some furniture or find a way for the cord to be accessible to the resident.</p>		Administrator or designee will sign off on the monthly audit ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.				

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R000154	<p>410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.</p> <p>Based on observation and interview, the facility failed to keep the oven in the kitchen in sanitary condition and maintained in good repair for 1 of 1 kitchen observations. This deficit practice had the potential to affect 34 of 34 residents currently residing in the building.</p> <p>Findings include:</p> <p>A kitchen sanitation tour was conducted on 10/21/2013 at 9:45 A.M., with the Dietary Manager. The two oven stove was observed with a thick dark residue on the oven doors. One of the ovens in particular was observed with the thicker layer of dark residue. Cook #1 indicated that one oven was, "broken".</p> <p>During an interview on 10/21/2013 at 10:10 A.M., with the Dietary Manager, she indicated it took hours to get the one oven up to temperature, so it was not used as a result.</p> <p>During an interview on 10/23/2013 at 10:55 A.M., the Dietary Manager</p>	R000154	<p>1. No resident was harmed. The oven doors were cleaned. The oven that was not working properly was repaired. 2. All residents have the potential to be affected. The dietary staff were in-serviced on proper cleaning and sanitation for the kitchen which included the ovens, (please see attachment F). 3. As a measure of ongoing compliance the Dietary manager or designee will check the ovens daily on regularly scheduled days ongoing to ensure they are sanitary and functioning properly, (please see attachment G). Should a deficient practice be noted, immediate corrective action will be taken. 4. As a measure of quality assurance the Administrator or designee will sign off on the audit weekly ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>	11/11/2013			

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	indicated the ovens had been in poor sanitary and general condition when she came a few months ago and she had been working on removing the layers of build up in them.			

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R000214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview, the facility failed to evaluate a resident after return from hospital for low blood sugar and a fall for 1 of 8 residents reviewed for evaluations in a sample of 8. (Resident B)</p> <p>Findings include:</p> <p>1. The record review for Resident B was completed on 10/21/13 at 1:45 P.M. Diagnoses included, but were not limited to diabetes, ruptured aneurysm, high blood pressure, neuropathy, and depression.</p> <p>The resident was admitted to the facility on 7/3/13. The Medication Self Administration Assessment dated 7/3/13 indicated, "...Cognitive ability : Adequate... Resident responsible for self administration after the responsible party/designee fills a weekly pill dispenser used to aid in proper medication administration on a daily basis-no. Resident responsible for self administration after receiving</p>	R000214	<p>1. Resident B was assessed and sent to the hospital. Resident B had a new Service plan completed to reflect her current status. Staff will assist resident B with care as appropriate. 2.All residents have the potential to be affected. All service plans were reviewed and revised accordingly. Nursing staff were educated on completing and reviewing/revising the service plan post re-admission and with significant changes, (please see attachment J). 3. As a measure of ongoing compliance the DON or designee will review five resident service plans monthly ongoing to ensure it is accurate. Any revisions will be completed accordingly, (please see attachment H). Should a deficient practice be noted, immediate corrective action will be taken. 4. As a measure of quality assurance the Administrator or designee will sign off on the audit monthly ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>	11/11/2013			

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	<p>pre-dispensed medication using the Docu-Dose system-no...5. Special medication needs (e.g. NTG) resident to self administer insulin injections list of method of storage that will be utilized in an effort to safeguard other residents from risk of hazard: resident keeps insulin bottles and syringes locked in room...."</p> <p>The nurses notes indicated, "...late entry 8/4/13 8:15 P.M. Resident was found in room laying on bed. Resident was unresponsive to touch and to call of name. Residents blood sugar was taken. Blood sugar read was 53. Resident vitals taken vitals were 164/65 with a pulse of 86. temperature was 97.8 respirations 20. Resident had urinated on self and was sweating profusely. Ambulance 911 was called and dispatched. The Director of Nursing was notified, the doctor and family was also notified. Upon arrival of 911 resident blood sugar was 35. Resident was taken to hospital for evaluation...."</p> <p>The document titled "Evaluation of needs/service plan" dated 7/8/13 indicated, "...H. Management of Oral Medications...unable to take medication unless administered by someone else...Special Instruction/Interventions Resident</p>			

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	<p>does own accu checks and gives self insulin...."</p> <p>A document titled level of Service Assessment/Evaluation dated 6/5/13 indicated, "...MEDICATION PROCEDURES-Caregiver administration and/or observation of medications requiring judgment for necessity, dosage and/or effect was noted a value of 10 and circled...."</p> <p>On 10/17/13 the physician wrote an order indicating, "...1) Nursing/staff to give insulin only 2) Patient is not to do accuchecks...."</p> <p>There was no updated service plan or level of service assessment to indicate the change in status of the resident's insulin administration and accuchecks.</p> <p>In an interview with the Executive Director on 10/23/13 she indicated the staff were watching the resident give herself the insulin as their staff are Qualified Medication Aids and are not able to give insulin injections and that the staff now complete the blood sugars. She indicated the current change was not reflected in the evaluation or service plan.</p> <p>2. The nurses notes for Resident B</p>						

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	<p>indicated, "...10/7/13 8:30 p.m. Resident was lying in apartment when a employee was checking on her, she came to tell QMA #4 she was on the floor V/S [vital signs] 140/70, 98.6, 72, 22. 8:45- She stated she did not hit head her arm was hurting. she did not request a pain pill. 8:50 - I called 911 to assist her off the floor she did not want to go to the hospital. 9:20 -Physician, family, and Director of Nursing [DON] notified. 9:35 Resident refused to go to hospital stated her family will take her. 10/8/13-3:30 p.m. Found resident in room in doggie style position in front of couch. Resident was trying to smoke electronic cigarette. Resident refused to have blood sugar taken and has no complaints of pain doctor and DON notified...."</p> <p>A reportable to the Indiana State Department of Health of unusual occurrences was provided by the administrator 10/23/13 at 10 A.M. The investigation was dated 10/8/13, with the incident date of 10/7/13 9:00 P.M. The brief description of the incident indicated, "...At approximately 9:00 pm QMA #5 came into Resident B's room. She stated she found her on the floor. She immediately went to get QMA #4 who was the QMA working at the time.</p>						

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	<p>911 was called to get her up and into her bed...."</p> <p>The document titled, "Evaluation of needs/service plan" dated 7/8/13 indicated, " ...D. Bathing : Ability to wash entire body... Able to bathe in shower or tub with assistance of another person... F. Ambulation/Locomotion: Ability to SAFELY walk once standing, or use a wheelchair, once seated on a variety of surfaces: Requires use of a device (e.g. walker) to walk alone or requires human supervision or assistance to negotiate stairs, steps, or uneven surfaces..."</p> <p>In an observation of Resident B's room on 10/22/13 at 1:00 p.m., her shower had an uneven surface at the bottom of her shower and a bath mat in front of the ledge on the floor.</p> <p>There was no evaluation completed after event on 10/7/13, regarding the resident attempt to shower independently, or regarding her fall.</p> <p>In an interview with the Executive Director on 10/23/13 at 1:15 p.m., she indicated the resident had attempted to shower independently before.</p>						

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	This Residential tag relates to the Complaint # IN00137809.						

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R000217	<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:</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>(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 include information regarding falls and behaviors on the service plan for 1 of 7 residents reviewed for service plans in a sample of 8. (Resident E)</p> <p>Findings include:</p>	R000217	<p>1. Resident E was not harmed. Resident E had previously been discharged from the facility. 2. All residents have the potential to be affected. All service plans were reviewed and revised accordingly. Nursing staff were educated on reviewing/revising the service plan with fall risk and behaviors with interventions, (please see</p>	11/11/2013			

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	<p>1. The record review for Resident E was completed 10/21/13 at 2:00 p.m. Diagnoses included, but were not limited to, lower extremity edema, dementia, neuropathy, and Parkinson syndrome.</p> <p>The resident had falls on: 3/19- found on floor-attempted to self transfer 3/20- missed toilet sit when went to sit down-on floor 4/12- 5 a.m. staff found resident on his back on floor next to bed-attempt self transfer. Fire department called and assisted resident back into bed. 4/17- 3:45 a.m. staff answered emergency light in bathroom and found resident sitting on floor facing toilet. resident tried to self transfer. Fire department called and assisted resident back into bed. 4/28- 6 p.m. answered call light and found resident on back and stated he missed his wheelchair when trying to self transfer. 4/30- 10:30 a.m. answered resident call light and resident was on floor next to bed. was trying to transfer self and missed. Fire department called and assisted resident back into bed. 5/5- 12 p.m. Resident was on the floor and missed when trying to self</p>		<p>attachment J). 3. As a measure of ongoing compliance the DON or designee will review five resident service plans monthly ongoing to ensure it is accurate. Any revisions will be completed accordingly, (please see attachment H). Should a deficient practice be noted, immediate corrective action will be taken. 4. As a measure of quality assurance the Administrator or designee will sign off on the audit monthly ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>				

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	<p>transfer to wheelchair from bed. 5/7- 5:30 p.m. resident trying to self transfer and slid from wheelchair to floor. 8 p.m. Call light answered to find resident on floor. 911 called. 5/8- 12:30 p.m. helping resident transfer from wheelchair to bed and resident fell forward after losing balance. 5/15- 11:30 a.m. Director of Nursing notified me that resident had fell, noted resident on the floor in the bathroom, assisted him, myself and the nurse in getting him up and into the chair. 5/23- midnight- resident had put on his call light and when went to answer resident was on the floor in the bathroom. 911 ambulance called and asked (name of resident) if he wanted to go to the hospital, resident said no. 5/30- 3:00 a.m. -found resident sitting on the floor in the bathroom, resident stating trying to self transfer to toilet and fell. Fire department called and assisted resident back into bed. 6/2- 7:30 p.m.-resident found on floor in bathroom by another resident, call light was not on, the other resident found nurse and told her resident is on the floor. Fire department called and assisted.</p> <p>The current evaluation of needs/service plan dated 2/26/13</p>						

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	<p>indicated, "...F. Ambulation/Locomotion: Ability to SAFELY walk once standing, or use a wheelchair, once seated on a variety of surfaces: ... Chairfast, unable to ambulate but is able to wheel self independently...We must assist resident in and out of his wheelchair, in and out of his bed, and dining room furniture at least five or more times a day...." There was nothing documented about falls or resident's behavior of trying to self transfer.</p> <p>In an interview with the Executive Director 10/22/13 at 11:10 a.m., she indicated the place on the service plan they would document a resident's having falls was section F.</p> <p>This Residential tag relates to the Complaint # IN00137809.</p>						

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R000241	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was taking medication as ordered by the physician for 1 of 8 residents in a sample of 8. (Resident B)</p> <p>Findings include:</p> <p>The record review for Resident B was completed on 10/21/13 at 1:45 P.M. Diagnoses included, but were not limited to diabetes, ruptured aneurysm, high blood pressure, neuropathy, and depression.</p> <p>The nurses notes indicated, "...late entry 8/4/13 8:15 P.M. Resident was found in room laying on bed. Resident was unresponsive to touch and to call of name. Residents blood sugar was taken. Blood sugar read was 53. Resident vitals taken vitals were 164/65 with a pulse of 86. temperature was 97.8 respirations 20. Resident had urinated on self and was sweating profusely. Ambulance</p>	R000241	<p>1. Resident B was not harmed. The resident was assessed for self administration and exhibited the ability to set the proper dose on the insulin pen and administer herself insulin properly. The physician was notified and an order was obtained indicating the resident is to set the dose on the insulin pen and inject her own insulin while staff observe. The resident will continue to be assessed for her ability to self administer medication on a quarterly basis and with any significant changes in condition. The physician will be notified of changes as indicated.</p> <p>2. All residents with insulin orders have the potential to be affected. All residents with orders for insulin are utilizing insulin pens. All residents requiring insulin injections have been assessed for self administration which includes setting the dose on the insulin pen and administering themselves insulin while the nursing staff observe. The physician was notified of the outcome of the assessments and appropriate</p>	11/11/2013			

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	<p>911 was called and dispatched. The Director of Nursing was notified, the doctor and family was also notified. Upon arrival of 911 resident blood sugar was 35. Resident was taken to hospital for evaluation...."</p> <p>On 10/17/13 the physician wrote an order indicating, "...1)Nursing/staff to give insulin only 2) Patient is not to do accuchecks...."</p> <p>During a medication pass observation on 10/22/13 at 11:30 A.M., Resident B was observed withdrawing insulin and giving it to herself after QMA (Qualified Medical Aid) #3 handed her the insulin and an insulin syringe. After this resident administered her own insulin, QMA #3 retrieved the insulin vial and the used syringe, then disposed of the insulin syringe and put the insulin vial away.</p> <p>During an interview with the Director of Nursing on 10/23/13 at 2:00 p.m., she indicated she had not received any clarification regarding the resident giving herself the insulin while staff observed. She indicated per their insulin policy the QMA's are not able to give insulin.</p>		<p>orders were obtained. The self administration assessments will be completed quarterly ongoing and with significant changes in condition. The physician will be notified of changes as indicated. All nursing staff were in-serviced on the medication administration policy, (Please see attachment J). 3. As a measure of ongoing compliance the DON or designee will complete an observation audit weekly ongoing to ensure staff are administering medications as ordered, (please see attachment I). Should a deficient practice be noted, immediate corrective action will be taken. 4. As a measure of quality assurance the Administrator or designee will sign off on the audit monthly ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>				

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R000242	<p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on observation, interview and record review, the facility failed to monitor the effects of a blood pressure medication for 1 of 6 residents reviewed for effectiveness of medications in a sample of 8. (Resident # 5).</p> <p>Findings include:</p> <p>During a medication pass observation on 10/22/2013 at 12:15 P.M., Resident # 5 was observed receiving, the PRN (as needed) medication for high blood pressure, Clonidine HCL 0.1 mg (milligrams).</p> <p>The facility's record titled, "PRN (PRO RE NATA) MEDICATIONS" was reviewed on 10/22/2013 at 11:00 A.M. This facility policy and procedure record indicated, "... nursing staff is responsible to monitor the resident and ensure that the PRN medication given was effective...."</p> <p>During an interview on 10/23/2013 at</p>	R000242	<p>1. Resident #5 was not harmed. Resident #5's blood pressure is monitored routinely and the physician is notified as indicated.</p> <p>2. All residents receiving PRN medications have the potential to be affected. All nursing staff were in-serviced on the PRN flow sheet and PRN medication administration with assessment prior to administration and post administration for efficacy and documentation, (please see attachment J).</p> <p>3. As a measure of ongoing compliance the DON or designee will review PRN flow sheets to ensure proper documentation is in place for the assessment completed before the PRN medication was administered and the efficacy of the medication daily on regularly scheduled days for 30 days, then three times weekly for 30 days, then weekly for 30 days, then monthly ongoing, (Please see attachment K). Should a deficient practice be noted, immediate corrective action will be taken.</p> <p>4. As a measure of quality assurance the Administrator or designee will sign off on the audit monthly ongoing. Based upon</p>	11/11/2013			

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	<p>11:30 A.M., with the Director of Nursing, indicated monitoring of affects of PRN medications were recorded on either the resident's PRN medication flow sheet or notes.</p> <p>Resident # 5's record was reviewed on 10/23/2013 at 12:00 P.M. The only PRN documentation record found for this resident, was next to this resident's medication administration record (MAR) and it was titled, "PRN Medication Flow Sheet...."</p> <p>The PRN medication flow sheet indicated, the blood pressure medicine, Clonidine HCL 0.1mg was administered :</p> <p>On 10/18/13 at 5:30 P.M., for a BP (blood pressure) of 177/100. No other BP was recorded to indicate the medication's effectiveness.</p> <p>On 10/22 at 12:15 P.M., for hypertension. No blood pressure was recorded to indicate the extent of the hypertension, and no blood pressure was recorded to indicate monitoring for the effectiveness of the medication given.</p> <p>On 10/22 at 11:00 P.M., for a BP of 169/92. No blood pressure was</p>		monitored findings, the plan of correction will be revised accordingly.				

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	<p>recorded to indicate monitoring for the effectiveness of the blood pressure medication.</p> <p>During exit on 10/23/2013 at 2:30 P.M., the facility was not able to provide any other documentation regarding the PRN medication monitoring for this resident.</p>						

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R000273	<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.</p> <p>Based on observation, interview and record review, the facility failed to follow safe sanitation of food temperature thermometers, lacked adequate monitoring of safe dish sanitation and the facility failed to dispose of expired chicken salad for 1 of 1 kitchen observations. This deficit practice had the potential to affect 34 of the 34 residents currently residing in the building that were served food from the kitchen.</p> <p>Findings include:</p> <p>1. During an observation on 10/21/2013 at 11:25 A.M., Cook #1 was observed rinsing the food temperature thermometer under running water and wiping it once on a paper towel before starting the food temperature checks. Then he was observed taking the food temperature of a food dish and then another without doing anything to sanitize the thermometer in between the 2 temperature checks.</p> <p>Record review of the facility's, " Food</p>	R000273	<p>1. Cook #1 was immediately re-educated on sanitization of the thermometer and how to mix the sanitizing solution and testing strips. Cook#2 was educated on the sanitizing solution and testing strips. The chicken salad dated 8/14/13 was immediately disposed of as well as the salads containing lettuce and carrots in bags. 2. All residents have the potential to be affected. All dietary staff were in-serviced in mixing sanitizing solution, utilizing testing strips, sanitizing of thermometers, and food storage, (please see attachment F). 3. As a measure of ongoing compliance the Dietary manager or designee will check the sanitizing solution and testing strips, monitor the thermometer sanitizing procedure, and monitoring the food storage in the refrigerator for proper date and label and disposal as appropriate daily on regularly scheduled days ongoing to ensure the facility policies are followed, (please see attachment G). Should a deficient practice be noted, immediate corrective action will be taken. 4. As a measure of quality assurance the Administrator or designee will sign off on the audit weekly</p>	11/11/2013			

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	<p>and Equipment Thermometers" policy and procedure and dated 11/12/2008, was completed on 10/22/2013 at 9:45 A.M. The procedure indicated : "... Wash, rinse and sanitize the thermometer before and after use. The thermometer may be sanitized with alcohol wipes or QUAT sanitizer...."</p> <p>During an interview with the Dietary Manager on 10/21/2013 at 2:10 P.M., she indicated she had alcohol pads in her office and needed to order more for the kitchen area. In addition she indicated she may need to do an inservice.</p> <p>On 10/21/2013 at 9:55 A.M., Cook #1 was observed checking the concentration of the sanitizing solution. He indicated the strip read 10 ppm (particles per million). He indicated that it should read 50 to 100 ppm. He was not sure if the testing strips were working.</p> <p>On 10/23/2013 at 9:05 A.M., Cook #2 was observed checking the concentration of the sanitizing solution. He indicated the strips were not working correctly or the solution was not mixed.</p> <p>On 10/23/2013 at 9:58 A.M., Cook #1</p>		ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.				

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	<p>was observed checking the dish sink for sanitation but he indicated he was unable because the strips were either the wrong ones or were not working.</p> <p>2. The kitchen tour with the Dietary Manager was completed on 10/21/2013 at 10:10 A.M. The walk in refrigerator was observed to have a number of salads in large plastic containers. One of the salads marked chicken salad was dated 8/14/2013.</p> <p>During an interview with the Dietary Manager, at the time, she indicated that it should have been disposed of. There were salads containing lettuce and carrots in bags that the dietary manager indicated also needed to be disposed of.</p> <p>The facility's record titled, "Storage of Leftovers" and dated 11/12/2008 was reviewed on 10/22/2013 at 2 P.M. The policy indicated food should be stored according to acceptable sanitation standards. The Procedure: "...Label and date all containers with a 'use by' date ...Cooked food products should be discarded after three days"</p>						

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R000300	<p>410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.</p> <p>Based on observation, interview and record review, the facility failed to label insulins, eye drop medication and a breathing medication with an open date for 1 of 2 medication carts observed.</p> <p>Findings include:</p> <p>The medication storage observation was completed on 10/22/2013 at 9:20 A.M., with QMA (Qualified Medication Assistant) #3. The insulin, Lantus, was observed with no open date on it; 2 Novolog insulins, were observed with no open dates on them; the eye drop medication, Ketotifen, was observed with no open date; the breathing medication, Spiriva, was observed with no open date.</p> <p>Record review of the facility's medication expiration policy was done on 10/22/2013 at 11:00 A.M., and the policy indicated, "...Any product whose expiration dating is dependent on the date of opening shall bear a</p>	R000300	<p>1. The medications were re-ordered and the date open was documented on said medications upon opening. 2. All residents medications whose expiration date is dependent on the date opened has the potential to be affected. All medications carts and refrigerators were checked to ensure all medications requiring the date opened be documented, has such documented. The nursing staff have been in-serviced on labeling of medications with the date open as indicated, (please see attachment J). 3. As a measure of ongoing compliance the DON or designee will audit the medication carts weekly ongoing to ensure all medications that require date open documentation have such documented, (Please see attachment L).Should a deficient practice be noted, immediate corrective action will be taken. 4. As a measure of quality assurance the Administrator or designee will sign off on the audits monthly ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>	11/11/2013			

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	<p>'DATE OPENED' on the prescription label"</p> <p>During an interview at that time with QMA #3, she indicated there were no open dates on the medications.</p>			
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R000304	<p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation and interview, the facility failed to ensure the medication cabinet was locked for 3 of 3 observations. This deficient practice had the potential to affect 34 of 34 residents residing in the building.</p> <p>Findings include:</p> <p>In an observation of the medication room/nursing station on 10/21/13 at 11 a.m., the door to the medication cabinet was noted to be slightly open and not locked. There were several types of medications in the cabinet. There was a sign on the cabinet door that indicated, " To be locked at all times"</p> <p>In an observation of the medication room/nursing station on 10/22/13 at 11:25 a.m., the door to the medication cabinet was noted to be slightly open and not locked. The Executive Director indicated at this time the door should be shut and</p>	R000304	<p>1. The medication cabinet lock was immediately replaced and locked. 2. All medication carts/cabinets have the potential to be affected. All nursing staff were in-serviced on medication storage, (see attachment J). 3. As a measure of ongoing compliance the DON or designee will audit the medication carts and cabinets weekly ongoing to ensure all are kept locked when unattended, (please see attachment L). Should a deficient practice be noted, immediate corrective action will be taken. 4. As a measure of quality assurance the Administrator or designee will sign off on the audits monthly ongoing. Based upon monitored findings, the plan of correction will be revised accordingly.</p>	11/11/2013			

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	<p>locked.</p> <p>In an observation of the medication room/nursing station on 10/22/13 at 4:20 p.m., the door to the medication cabinet was noted to be slightly open and not locked.</p> <p>During the environmental tour on 10/23/13 at 11:20 a.m., the Executive Director indicated the cabinet door lock was broken.</p>			
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