

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 05/30/2012
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NAME OF PROVIDER OR SUPPLIER GARDENS AT LAKE CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580
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R0000	<p>This visit was for the Investigation of Complaints IN00107650 and IN00108329.</p> <p>Complaint IN00107650-Substantiated. State residential deficiencies related to the allegations are cited at R036.</p> <p>Complaint IN00108329-Substantiated. State deficiencies related to the allegations are cited at R036.</p> <p>Survey dates: 5/24, 29, 30/12.</p> <p>Facility Number: 011389 Provider Number: 011389 Aim Number: n/a</p> <p>Survey Team: Ellen Ruppel, RN, TC (5/29-30/12) Honey Kuhn, RN (5/24/12)</p> <p>Census bed type: Residential: 26 Total: 26</p> <p>Census payor type: Other: 26 Total: 26</p> <p>Sample: 11</p>	R0000		

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>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 6/4/12 Cathy Emswiller RN</p>				

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R0036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interviews, the facility failed to administer medications as ordered by the physician, placed medications on hold without a physician's order and failed to notify the physician when holding medications for three residents in a sample of 11. Residents F, H and K.</p> <p>Findings include:</p> <p>1. The clinical record of Resident F was reviewed, on 5/30/12 at 6:00 a.m., and indicated the resident had been admitted to the facility on 3/12/09, with diagnoses including, but not limited to: diabetes, dementia and hypertension.</p>	R0036	<p>Resident F and H had no parameters for holding Metformin. Resident F and H have physician orders to call for blood sugars <60 or >350. Documentation of physician notification will be the resident's medical record. Records of Residents with Metformin were reviewed by the Wellness Director and physician notification orders were received if necessary. A copy of the physician notification will be in the resident's medical record and MAR will be marked accordingly. Wellness Director will review physician orders of incoming Residents who are receiving Metformin to confirm physician notification orders prior to starting the medication. Wellness Director (WD) will review Metformin physician orders monthly for 4 months for physician notification parameters and will compare them to the MARS for accuracy. T he Regional Director of Quality and Care Management (RDQCM) will review the Medication</p>	06/15/2012			

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	<p>Review of the Medication Administration Record (MAR) for the month of May 2012, indicated the resident's Metformin (for diabetes) had not been given at 4:00 p.m., on 5/11/12 or 5/16/12. The back of the MAR indicated the medication was held on 5/11/12 due to a blood sugar of 115 and held again on 5/16/12, when the resident's blood sugar was 69.</p> <p>Review of physician's orders, dated 4/26/11, indicated no parameters for holding the medication and no documentation the physician was notified about the nurse not giving the medication.</p> <p>2. Review of the clinical record of Resident H, on 5/30/12 at 7:30 a.m., indicated she had been a resident in the facility since 11/4/11. Her diagnoses included, but were not limited to: diabetes, hypertension and gastric reflux.</p> <p>Review the May 2012, MAR indicated the resident's twice daily</p>		<p>Administration Records (MAR) for physician call parameters monthly for 4 months and then quarterly thereafter to ensure compliance.</p> <p>Resident K had no parameters for holding Ferrous Sulfate. Ferrous Sulfate was held due to resident not eating and Ferrous Sulfate is to be taken with food.</p> <p>If Resident K cannot eat after being offered snacks, and observed at all meals the physician will be notified. Documentation of physician notification will be the resident's medical record.</p> <p>Residents with Ferrous Sulfate will be given the medication with food. If the resident cannot eat after attempts at snacks and additional meals the resident's physician will be notified. Documentation of physician notification will be in the resident's medical record. Residents with Ferrous Sulfate will be given the medication with food. If the resident cannot eat after attempts at snacks and additional meals the resident's physician will be notified. Staff will be re-educated on policy and procedure on 6-15-12.</p> <p>WD to be notified if resident is not eating. WD will assist staff offering food to resident so that they can safely take their Ferrous Sulfate.</p> <p>RDQCM will audit MARs for omitted Ferrous Sulfate to determine proper physician</p>				

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	<p>Metformin had been held nine times during the month. The back of the MAR indicated the reason for holding it was "ate 25% on 5/16/12, ate 50% on 5/17 at breakfast, ate little on 5/17 (during the evening), ate poor on 5/3, 5/7, 5/21, 5/24 and 5/28/12." There was no documentation to indicate the physician had been notified the facility was not giving the Metformin as ordered or parameters for administration had been established.</p> <p>Review of the 11/28/11, physician's orders, on 5/30/12 at 7:35 a.m., indicated no parameters for holding the Metformin.</p> <p>3. The clinical record for Resident K was reviewed, on 5/29/12 at 2:30 p.m., and indicated the resident had lived in the facility since 8/29/10. His diagnoses included, but were not limited to: atrial fibrillation and anemia.</p> <p>Review of the MAR for May 2012,</p>		communication for 4 months and then quarterly X 4 quarters.				

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	<p>on 5/29/12 indicated the nurse had held the resident's ferrous sulfate (iron) on 5/26/12 at 5:00 p.m., and the reason listed on the back of the MAR was "didn't eat supper."</p> <p>There was no documentation to indicate a snack or later offering of the medication had occurred. The most current laboratory test, of 5/15/12, indicated a low hemoglobin of 8.7 (normal being 12.5-17).</p> <p>Review of physician's orders, dated 5/14/12, indicated no parameters for holding the iron preparation.</p> <p>During an interview with RN #1, on 5/30/12 at 9:00 a.m., she indicated the nurses were to call for specific parameters for holding of medications and notify the physician when medications needed to be held.</p> <p>This residential finding relates to Complaints IN00107650 and IN00108329.</p>						

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