

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 01/25/2013
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NAME OF PROVIDER OR SUPPLIER ELMCROFT OF MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 N MORRISON RD MUNCIE, IN 47304
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R0000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: January 23, 24. 25, 2013</p> <p>Facility number: 010886 Provider number: 010886 AIM number: N/A</p> <p>Survey Team: Ginger McNamee, RN Betty Retherford, RN</p> <p>Census bed type: Residential: 80 Total: 80</p> <p>Census payor type: Other: 80 Total: 80</p> <p>Sample: 7</p> <p>These state findings are in accordance with 410 IAC 16.2</p> <p>Quality review completed by Debora Barth, RN.</p>	R0000	<p>The filing of this plan of correction is complete as evidenced by the communities desire to comply with Indiana's regulatory requirements and to continue providing quality of care to our residents. This plan of correction serves as our allegation of substantial compliance. To assure regulatory compliance the community has taken the following measures:</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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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 interview, the facility failed to promptly notify the attending physician and hospice services when the resident developed open areas requiring a possible change in treatment order for 1 of 1 resident reviewed for physician notification of pressure areas in a sample of 7. (Resident #6)</p> <p>Findings include:</p> <p>The clinical record for Resident #6 was reviewed on 1/23/13 at 9 a.m.</p> <p>Diagnoses for Resident #6 included, but were not limited to, Alzheimer's dementia with aggressive behaviors, prostate cancer, anemia, and arthritis.</p> <p>The clinical record indicated the resident received hospice services due to a malignant neoplasm of the prostate and end stage Alzheimer's</p>	R0036	<p>410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights It is the policy of Elmcroft of Muncie to notify the resident's primary care physician and/or specialist of significant changes in the resident's condition or anytime pertinent physician notification is required under State Regulations. Each Licensed staff member will be re-inserviced and educated on 2/11/2013 regarding the policy and procedure on Physician Notification. The Resident Service Director and or designee will monitor daily the 24 hour report sheet for changes in condition and any pertinent documentation requiring physician notification. All staff will be inserviced on residents rights. Resident Service Director and/or designee to monitor daily for compliance. Completion Date: 2/11/2013</p>	02/11/2013			

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	<p>disease. A health care plan, last updated in November 2012, indicated the resident was terminally ill and received hospice services. One of the approaches for this problem indicated "Comfort measures as needed: ...c. skin care...."</p> <p>A recapitulation of physician's orders, dated 11/1/12, indicated the resident had an order for Calmoseptine ointment to be applied topically to bilateral buttocks as needed for redness/excoriation. The order lacked any information related to how many times daily the ointment could be applied when needed. The Treatment Administration Record (TAR) for December 2012 lacked any documentation of the treatment being needed and/or applied from 12/1/12-12/18/12.</p> <p>A nursing note entry, dated 12/19/12 at 1:30 p.m., indicated "Noted 2 OA [open areas] to buttocks. OA to R [right] buttock measures 1.3 by 1.2 [centimeters], L [left] buttock measures 0.3 by 0.3. Prn [as needed] Calexyeme [sic] [same as Calmoseptine] applied." The administration of the prn treatment on December 19, 2012 was documented on the December TAR. This is the only time in the month of December</p>						

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	<p>2012 that the treatment was documented as having been done.</p> <p>The clinical record lacked any information related to the hospice nurse having been made aware of the development of two open areas on the resident's buttocks until 12/27/12 at 1:45 p.m. This indicated a time period of 8 days from the time the open areas were noted until the hospice nurse and/or hospice provider services were notified.</p> <p>The clinical record lacked any information related to the resident's physician having been made aware of the open areas noted on 12/19/12 until 1/4/13. This indicated a time period of 16 days from the day the open areas were noted and the physician was notified.</p> <p>During an interview with the Administrator and DoN on 1/24/13 at 8:40 a.m., additional information was requested related to the delay in notifying the physician and hospice nurse of the resident's open areas noted on 12/19/12.</p> <p>During an interview on 1/24/12 at 1:45 p.m., the DoN indicated she had no information to provide related to the delay in notification of the</p>						

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	<p>resident's open areas to the hospice provider and physician as noted above.</p> <p>The 3/8/12, revised policy for "Physician Notification Regarding Resident's Condition" was provided by the Director of Nursing on 1/24/13 at 10:25 a.m. The purpose of the policy indicated: "It is the policy of Elmcroft that when the Executive Director [Administrator,] Resident Services Director [Director of Nursing,] or other responsible person feels the primary physician or specialist of a resident should be consulted on health concerns, the following steps should be taken. Policy: ...Possible reasons for contacting physician: ...Any time notification of a physician is required under state regulations. Any condition or incident which requires documentation on an incident report should be reported to the physician.</p>				

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R0349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure treatment orders were specific as to how many times daily the ointment could be applied and failed to ensure wound treatments were documented as provided for 1 of 1 resident reviewed for documentation of pressure ulcer treatment in a sample of 7. (Resident #6)</p> <p>Findings include:</p> <p>The clinical record for Resident #6 was reviewed on 1/23/13 at 9 a.m.</p> <p>Diagnoses for Resident #6 included, but were not limited to, Alzheimer's dementia with aggressive behaviors, prostate cancer, anemia, and arthritis.</p> <p>The clinical record indicated the resident received hospice services due to a malignant neoplasm of the prostate and end stage Alzheimer's</p>	R0349	<p>It is the policy of Elmcroft of Muncie that all medications be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional. All MARs/TARs shall have the resident's identifying data clearly noted on the record to include: prescribed medication, dosage, label instructions for use, times to be administered, initials of person who administered medications at the time medications are given. All prn medications must have time indicated under employee initial, with why med given and effectiveness documented on back of MAR/TARs. All licensed staff will be inserviced on 2/11/13 regarding policy and procedure on Documentation including prn documentation of MAR/TARs. All licensed staff will be inserviced 2/11/13 regarding the completion of and thoroughness of physician's orders. Resident Service Director, effective 2/5/13, is completing one-on-one orientation on all aspects of</p>	02/11/2013			

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	<p>disease.</p> <p>A recapitulation of physician's orders, dated 11/1/12, indicated the resident had an order for Calmoseptine ointment to be applied topically to bilateral buttocks as needed for redness/excoriation. The order was incomplete and lacked any information related to how many times daily the ointment could be applied when needed.</p> <p>A nursing note entry, dated 12/19/12 at 1:30 p.m., indicated "Noted 2 OA [open areas] to buttocks. OA to R [right] buttock measures 1.3 by 1.2 [centimeters], L [left] buttock measures 0.3 by 0.3. Prn [as needed] Calexyeme [sic] [same as Calmoseptine-a skin care treatment] applied." The administration of the prn treatment on December 19, 2012 was documented on the December TAR. This is the only time in the month of December 2012 that the treatment is documented as having been done.</p> <p>A hospice nurse progress note, dated 12/27/12 at 1:45 p.m., indicated the hospice nurse had visited the resident and noted two pressure ulcers, one on the resident's coccyx and one on the resident's right buttock. The note</p>		documentation with all new hires who are licensed. RSD and/or Designee to review copies of all new orders weekly for completion and accuracy. This will be on-going.				

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	<p>indicated Calazime [Calmoseptine] ointment had been applied. The Treatment Administration Record (TAR) for Resident #6 lacked any documentation of the treatment having been provided on 12/27/12.</p> <p>During an interview with the Administrator and DoN on 1/24/13 at 8:40 a.m., additional information was requested related to the incomplete treatment order and the lack of documentation of wound care having been provided.</p> <p>During an interview on 1/24/12 at 9:15 a.m., the DoN provided weekly "Skin Condition Reports" which contained wound measurements and "7 Day Charting Comments" related to the open areas noted above found on 12/19/12. The report had weekly entries, dated 12/19/12, 12/26/12, and 1/4/13, that indicated the wounds were being measured weekly and treated with the as needed Calazime ointment. The DoN indicated the nursing staff had failed to document the treatments having been completed on the TAR. She indicated the incomplete treatment order had been corrected on 1/7/12 to "once every shift and as needed."</p> <p>The current facility policy, titled</p>						

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	<p>"Medication Administration," dated 8/1/11, was provided by the DoN on 1/25/13 at 11:15 a.m. She indicated the same procedure would be followed for treatment administration. The policy included, but was not limited to, the following:</p> <p>"Purpose: It is policy of Elmcroft that all medications be given, taken, or applied pursuant to labeling instructions or signed orders by the prescribing licensed health care professional....</p> <p>Policy: ... The Medication Assistance Record [MAR] shall have the Resident's identifying data clearly noted on the record to include the medication prescribed, the dosage, label instructions for use, times to be administered, and the initials of the person who administered the medication, which shall be entered at the time the medication is given....</p> <p>Prn medications must have time indicated under employee initial, with why the medicine was given and it effectiveness documented on the back of the MAR...."</p>						