

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	<p>This visit was for the Investigation of Complaint IN00130020.</p> <p>Complaint IN00130020 Substantiated. Federal/state deficiencies related to the allegations are cited at F157.</p> <p>Survey dates: June 5, 6, 2013</p> <p>Facility number: 000188 Provider number: 155291 AIM number: 100266310</p> <p>Survey team: Connie Landman RN TC</p> <p>Census bed type: SNF: 4 SNF/NF: 89 Total: 93</p> <p>Census payor type: Medicare: 10 Medicaid: 69 Other: 14 Total: 93</p> <p>Sample: 5</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey Review on or after 6/21/13.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality Review completed on 06/07/2013 by Brenda Nunan, RN.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/06/2013
NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure physician notification of blood sugars higher than the parameters ordered by the physician for 1 of 3 diabetic</p>	F000157	1. The resident no longer resides at the facility. 2. All residents who are diabetic and have accu-check orders are at risk to be affected. All licensed staff to be re-educated on Blood Glucose	06/21/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/06/2013
NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>residents reviewed for blood sugars in a sample of 5 (Resident B).</p> <p>Findings include:</p> <p>The record for Resident B was reviewed on 6/5/13 at 4:20 P.M.</p> <p>Diagnoses included, but were not limited to, pemphigoid, dementia, depression, hypertension, ischemic heart disease, osteoporosis, osteoarthritis, and diabetes mellitus.</p> <p>A care plan, dated 9/6/11 and last reviewed on 3/21/13, indicated the resident was at risk for adverse effects of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). Interventions included, but were not limited to, document abnormal findings and notify MD.</p> <p>A physician's order, dated 3/15/13, indicated accuchecks (fingerstick blood tests to measure blood sugars) were to be done twice a day, and the MD was to be called for blood sugars less than 60 or higher than 400.</p> <p>The Capillary Blood Glucose Monitoring Tool, for April, 2013, had documentation of elevated blood sugars on: 4/15/13 at 6:00 A.M. blood sugar 424</p>		<p>Monitoring by 6/21/13 by the Staff Development Coordinator. The charts of all residents with diagnosis of diabetes will be audited to ensure the physician was notified per physician order.</p> <p>3. The nurse management team will audit the blood glucose flow sheets of all residents who are diabetic and have accu-checks to ensure the physician was notified per physician order. The audits will be conducted daily for two weeks, three times per week for four weeks, and weekly thereafter.</p> <p>4. The Director of Nursing will review audit results. The Glucometer compliance audit tool will be completed weekly for 2 months, and monthly for at least six months. If threshold of 95% is not achieved an action plan will be developed. -Date of Correction 6/21/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/06/2013
NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>4/16/13 at 6:00 A.M. blood sugar 455 4/17/18 at 6:00 A.M. blood sugar 418 4/18/13 at 4:00 P.M. blood sugar 414</p> <p>The Capillary Blood Glucose Monitoring Tool for April, 2013, and the Nursing Progress Notes for these dates and times lacked documentation the physician had been notified of the abnormal blood sugar readings.</p> <p>During an interview with the DNS (Director of Nursing Services) on 6/6/13 at 2:30 P.M., she indicated she had been unable to find documentation to indicate the physician had been notified of the abnormal blood sugar readings.</p> <p>A current facility policy, dated 3/10, titled "Blood Glucose Monitoring" provided by the DNS on 6/6/13 at 1:30 P.M. indicated, "...The physician will be notified when the resident's blood glucose is outside the physician stated parameters or if the resident is experiencing signs or symptoms of high or low blood sugar...."</p> <p>This federal tag relates to Complaint IN00130020.</p> <p>3.1-5(a)(3)</p>				

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

PRINTED: 07/05/2013

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155291	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER  EAGLE VALLEY MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	