

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155455	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/17/2014
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NAME OF PROVIDER OR SUPPLIER  WESLEYAN HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: June 10, 11, 12, 13, 16 and 17, 2014</p> <p>Facility number: 000557 Provider number: 155455 AIM number: 100291240</p> <p>Survey team: Jason Mench, RN, TC Angela Selleck, RN (June 10, 12, 13, 16 and 17, 2014) Kim Davis, RN (June 10, 11, 12, 13 and 17, 2014) Shelly Reed, RN</p> <p>Census bed type: SNF: 12 SNF/NF: 112 Residential: 8 Total: 132</p> <p>Census payor type: Medicare: 12 Medicaid: 91 Other: 29 Total: 132</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		

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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F000309 SS=D	<p>Quality review completed by Debora Barth, RN.</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 interview, and record review, the facility failed to ensure assessments were completed for 2 residents. This failure was evidenced by accurate documentation and monitoring of weights for 1 of 3 residents reviewed for weights (# 120), and assessments of abnormal blood glucose tests for 1 of 5 residents reviewed for unnecessary medications (# 52).</p> <p>Findings Include</p> <p>1. The clinical record of Resident #120 was reviewed on 6/17/14 at 8:50 a.m. The record indicated the resident's diagnoses included, but were not limited to, shock, muscle weakness, dysphasia, esophageal reflux, peripheral neuropathy,</p>	F000309	In lieu of survey results, the facility respectfully requests a paper review. The facility is unable to correct the alleged deficient practice for resident #120 regarding weight documentation as she was discharged from the facility on 5-31-14. All resident's have the potential to be affected by the alleged deficient practice. The facility will conduct an audit for all residing residents reviewing a weight history for the last 60 days to ensure that no other resident has been affected by the alleged inaccurate weight documentation. All nursing staff will be inserviced regarding appropriate weight documentation and systematic changes being implemented regarding weights. Each resident is weighed at admission and will be reweighed the following day after admission	07/17/2014	

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	<p>and pancreatic cancer.</p> <p>The following weights were recorded in the resident's clinical record...</p> <p>1/3/14:195 pounds 1/13/14:182 1/20/14:168 1/28/14:150 2/7/14: 154 2/18/14:150 3/18/14: 152 4/22/14: 155 5/21/14: 157</p> <p>A clinical record included progress notes made by the dietician on 1/14/14 and 1/23/14. The notes included the weights as documented in the clinical record.</p> <p>Further review of the clinical record provided no assessments related to fluid overload, large amounts of edema, or further evaluations of the reasons for the resident's 35 pound weight loss in 25 days.</p> <p>The Care Plan, dated 1/20/14, did not address weight loss.</p> <p>The Unit Manager was interviewed on 6/17/14 at 12:45 p.m. During the interview, the Unit Manager indicated Resident #120's weight loss was not addressed by the facility Nutrition at Risk</p>		<p>to ensure the accuracy of the weight.Unit Managers are to review the new admission weights on the next business day to ensure weight accuracy documentation is occurring. The Dietary Manager is to review admission and next day weights ensuring accuracy of the weight documentation. Dietary Manager is to additionally review admission weights with the Nutrition At Risk Meeting weekly. Results of the dietary Manager's weight checks to be reviewed at the montly QA meetings ongoing.The facility is unable to correct the alleged deficient practice for resident number 52 regarding blood glucose documentation. No resident number 54 resides in the facility.All residents have the potential to be affected by the alleged deficient practice.The Unit Managers/designee are to conduct a blood glucose audit for the last 30 days for all applicable residents to ensure that no other residents have been affected by the alleged deficient practice. The DON/designee is to review the results upon completion.All nursing staff will be inserviced on abnormal blood glucose documentation.DON/designee to conduct an audit of blood glucose levels each business day to ensure any residents with abnormal blood glucose levels have an appropriate assessment documented. The audit will be performed daily times 4 weeks,</p>		

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	<p>Committee. She indicated the resident's weight at the hospital on 12/22/13 was 179. She indicated the admission weight recorded on 1/3/14 of 195 was possibly inaccurately documented, but a second weight was not obtained. The unit manager indicated weight loss of Resident #120 was not reviewed as loss and not assessed.</p> <p>2. The clinical record of Resident #52 was reviewed on 6/12/14 at 1:00 p.m. The record indicated the resident's diagnosis included, but were not limited to, diabetes.</p> <p>The record indicated insulin was administered to Resident #52 everyday before meals. Prior to the administration, staff tested the resident's blood glucose levels. The physician was to be called if the blood glucose reading was below 60 mg/dl (milligrams per deciliter) or above 400 mg/dl.</p> <p>The clinical record indicated on 5/5/14 at 7:30 a.m., the resident's blood glucose level was 45 mg/dl, and 44 mg/dl at 5:51 p.m. There were no assessments of the abnormally low blood glucose readings in the clinical record.</p> <p>The clinical record indicated on 6/2/14 at 11:25 a.m., the resident's blood glucose</p>		twice weekly times 4 weeks and then one time weekly ongoing.		

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	<p>reading was 402 mg/dl. The clinical record provided no documented assessment of the abnormally high blood glucose test.</p> <p>LPN #3 was interviewed on 6/12/14 at 3:00 p.m. During the interview, LPN #3 indicated assessments were to be completed for abnormal blood sugars in the clinical record.</p> <p>LPN #4 was interviewed on 6/17/14 at 10:00 a.m. During the interview, LPN #4 indicated when a blood glucose test was below 60 mg/dl or above 400 mg/ml, the test was abnormal and the physician was notified.</p> <p>The Unit Manger was interviewed on 6/17/14 at 9:45 a.m. During the interview, the Unit Manager indicated assessments were not completed for the abnormal blood glucose tests on 5/5/14 or 6/2/14 for Resident #54.</p> <p>The facility policy entitled, ADMINISTRATIVE ASSESSMENTS/EVALUATIONS", dated 3/2012, was presented by the Director of Nursing on 6/17/14 at 2:00 p.m. The policy indicated, " Assessments will be completed on: admission/re-admission, quarterly, and with significant change, or as stated in</p>						

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F000314 SS=D	<p>specific policies..."</p> <p>3.1-37(a)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on interview, and record review, the facility failed to ensure the accuracy of assessments for treatment of a pressure sore for 1 of 2 residents reviewed for pressure sores. (#120)</p> <p>Findings Include</p> <p>1. A. The clinical record of Resident #120 was reviewed on 6/17/14 at 8:50 am. The record indicated the resident's diagnoses included, but were not limited to, shock, muscle weakness, dysphasia, esophageal reflux, peripheral neuropathy, and Pancreatic cancer.</p> <p>The facility document entitled, "Admission Note, Skin Observation",</p>	F000314	The facility is unable to correct the alleged deficient practice for resident 120 as they were discharged from the facility on 5-31-14. All residents have the potential to be affected by the alleged deficient practice. The wound nurse will conduct an audit of all Braden assessments for those residents admitted to the facility in the last 30 days to ensure that no other resident has been affected by the alleged deficient practice. All nursing staff will be inserviced regarding pressure ulcers and accurate assessment of an area. The wound nurse/designee is to conduct a skin assessment on all new admits each business day to ensure accuracy of admission assessments. Any concerns to	07/17/2014			

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	<p>dated 1/3/14, indicated Resident #120 had a 5 centimeter (cm) by 4 cm area of MASD (moisture associated skin damage) on the coccyx. The note indicated the resident's skin was pink, the turgor was good, and skin was intact.</p> <p>The "Admission Braden Scale" (a test that defines a resident's risk for pressure sore development), dated 1/3/14, indicated Resident #120 was not at a high risk for the development of pressure areas.</p> <p>The facility document entitled, "TLC Skin Observations", dated 1/3/14, indicated "...skin is warm... no open areas..."</p> <p>The facility document entitled, "Transfer/Discharge Skin Assessments", dated 1/8/14, indicated "... No open areas..."</p> <p>The facility documentation entitled, "Pressure Ulcer Progress Report", dated 1/7/14, indicated a five by four cm pressure sore on Resident #120's coccyx.</p> <p>The Care Plan, dated 1/23/14, did not include a pressure sore.</p> <p>The current facility Wound Nurse was interviewed on 6/17/14 at 1:00 p.m. During the interview, the wound nurse</p>		be forwarded to the DON for review. Any concerns regarding admission skin assessments to be reviewed at monthly QA meetings times 4 months, then quarterly				

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	<p>indicated pressure sore measurements and assessments are to be completed by the wound nurse. The wound nurse indicated the facility wound nurse was out sick on 1/3/14 and did not assess Resident #120. The wound nurse indicated the nurse who completed the admission assessment on 1/3/14 was the back up wound nurse. The wound nurse indicated Resident #120's pressure sore was not accurately assessed until 1/7/14, four days after admission.</p> <p>The facility policy entitled, " Procedure When Wound is Found", dated 10/10, was presented by the Director of Nursing on 6/17/14 at 2:00 p.m. The policy indicated, "... When an open area is identified, either on admission acquired, the following procedure is to be followed: Document all new areas on "Point of Care... ...Observe the wound including all the following: a. Size DO NOT STAGE THE WOUND b. Color c. Odor d. Drainage e. Describe the surrounding tissue. NOTE: Use the word "wound" not open area...."</p>			

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F000356 SS=C	<p>3.1-40(a)(2)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, interview, and</p>	F000356	The facility is unable to correct the alleged deficient practice of	07/17/2014			

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F000431 SS=D	<p>record review, the facility failed to ensure posted nursing staff information was accurate and up to date for 1 of 6 days of the survey (6/10/14). This practice had the potential to affect 132 of 132 residents who resided in the facility.</p> <p>Findings include:</p> <p>During initial tour on 6/10/14 at 9:30 a.m., the posted nursing staff information form was found to be posted with an incorrect date of 6/9/14.</p> <p>During an interview on 6/17/14 at 2:15 p.m., the Director of Nursing indicated the nurse staff information was available and posted after the morning meeting at approximately 10:00 a.m. each day.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility</p>		<p>the innaccurate posted nursing hours.All residents have the potential to be affected by the alleged deficient practice.Nursing Staff will be inserviced regarding posting hours. A facility nurse will be responsible to post the hours at the beginning of each shift.The staffing coordinator/designee will be responsible to review the accuracy of the posted hours on each business day.QA is to review system accuracy of nurse posting hours monthly times 4 then quarterly thereafter.</p>				

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	<p>must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to properly dispose of medication for 1 of 8 residents observed during medication administration. (Resident 9; QMA # 1)</p> <p>1. Medication administration was observed on 6/16/14 at 8:30 a.m. While observing QMA #1, a pill dropped from the punch card and rolled onto the floor. The QMA was aware the pill dropped and replaced it with another pill. The QMA proceeded to administer the medication to the resident. After the administration of the medication, the</p>	F000431	The facility is unable to correct the alleged deficient practice of improper medication disposal. All residents could be affected by the alleged deficient practice. Nurses/QMA's to be inserviced regarding medication destruction. Med pass observations of 3 residents to be conducted 2 times weekly times 4 weeks, then weekly times 4, then 2 times monthly ongoing by the Unit Managers. DON/designee to review medication pass observation results weekly. QA committee to review results of medication pass observations quarterly ongoing.	07/17/2014

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F000520 SS=D	<p>QMA proceeded to the resident in the next bed. The pill remained on the floor in sight for 15 minutes. QMA #1 continued to administer medication to two additional residents. At 8:45 a.m., QMA was reminded the pill was still on the floor. She indicated the pill was Torsemide (diuretic) 40 mg. She indicated she forgot to pick up the pill and dispose of it.</p> <p>Review of a current undated facility policy, provided by the Corporate Nurse on 6/16/14 at 2:33 p.m., titled "Destroying Medications", included, but was not limited to:</p> <p><u>Purpose:</u> To establish uniform guidelines concerning the destruction of medications.</p> <p><u>General Guideline:</u> ....4. All medications, with the exception of narcotics, are to be placed into the blue medication disposal container.</p> <p>3.1-25(o)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee</p>						

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	<p>consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review, and interview, the facility failed to develop and implement appropriate plans of action to address accurate documentation and monitoring of weights as identified during the Annual Recertification and State Licensure survey. (Resident #120.)</p> <p>Findings include:</p> <p>During an interview on 6/17/14 at 2:39 p.m., the Administrator, Nurse Consultant and the Director of Nursing were queried regarding QAA (Quality Assurance and Assessment) and the identified concern of the annual survey concerning accurate documentation and</p>	F000520	The facility is unable to correct the alleged deficient weight documentation accuracy. All residents have the potential to be affected by the alleged deficient practice. The facility will conduct an audit for all residing residents reviewing a weight history for the last 60 days to ensure that no other resident has been affected by the alleged inaccurate weight documentation. All nursing staff will be inserviced regarding appropriate weight documentation and systematic changes being implemente regarding weights. Each resident is weighed at admission and will be reweighed the following day after admission to ensure the accuracy of the weight. Unit Managers are to	07/17/2014

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R000000	<p>monitoring of weights for Resident #120.</p> <p>During an interview on 6/17/14 at 2:50 p.m., the Administrator, Nurse Consultant and the Director of Nursing indicated there was no action plan or evaluation in place for the accurate documentation and monitoring of weights included in the QAA program.</p> <p>3.1-52(b)(2)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: June 10, 11, 12, 13, 16 and 17, 2014</p> <p>Facility number: 000557 Provider number: 155455 AIM number: 100291240</p> <p>Survey team: Jason Mench, RN, TC Angela Selleck, RN (June 10, 12, 13, 16 and 17, 2014) Kim Davis, RN (June 10, 11, 12, 13 and</p>	R000000	<p>review the new admission weights on the next business day to ensure weight accuracy documentation is occurring. The Dietary Manager is to review admission and next day weights ensuring accuracy of the weight documentation. Dietary Manager is to additionally review admission weights with the Nutrition At Risk Meeting weekly. Results of the dietary Manager's weight checks to be reviewed at the montly QA meetings ongoing.</p>	

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NAME OF PROVIDER OR SUPPLIER  WESLEYAN HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 729 W 35TH ST MARION, IN 46953			
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R000247	<p>17, 2014) Shelly Reed, RN</p> <p>Census bed type: SNF: 12 SNF/NF: 112 Residential: 8 Total: 132</p> <p>Census payor type: Medicare: 12 Medicaid: 91 Other: 29 Total: 132</p> <p>Residential sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview and</p>	R000247	The facility is unable to correct the alleged deficient practice for	07/17/2014			

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	<p>record review, the facility failed to ensure residents received the correct dose of medication according to the current physician order for 1 of 5 residents reviewed during medication administration. (Resident H). The facility also failed to ensure a medication error rate of less than 5 percent for 1 of 18 medications observed affecting 1 of 5 residents resulting in a medication error rate of 5.5%. (Resident H; LPN # 2)</p> <p>Findings include:</p> <p>1. During medication administration observation on 6/17/14 at 3:00 p.m., LPN #2 administered Hydrocodone-Acetaminophen (pain medication) 5/325 mg to Resident (H).</p> <p>During review of the Medication Administration Record (MAR), provided by the Director of Nursing (DoN) on 6/16/14 at 3:30 p.m., the current physician's order indicated Resident (H) should have received Hydrocodone-Acetaminophen 5/500mg twice daily.</p> <p>During an interview on 6/16/14 at 3:38 p.m., the DoN indicated the nurse gave the wrong medication and the physician was notified. She indicated the facility wrote a medication error report for</p>		<p>resident H regarding medication administration. All residents have the potential to be affected by the alleged deficient practice. The facility will conduct an audit for all residing residents in Assisted Living for last 30 days to ensure that no other resident has been affected by the alleged medication administration deficit. All nursing staff will be inserviced regarding the rights of medication administration. Medication observation of 3 residents to be conducted 2 times weekly times 4 weeks, then weekly times 4 weeks, then 2 times monthly ongoing by Unit Manager/designee. DON/designee to review medication pass documentation results weekly. QA committee to review results of medication pass observations quarterly.</p>		

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R000408	<p>Resident (H).</p> <p>2. There were 18 opportunities for medication errors during the medication pass observations. One error resulted. This made the error rate equal to 5.5%.</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review, the facility failed to ensure residents received a tuberculin skin test on admission for 1 of 7 sampled residents. (Resident G)</p> <p>Findings include:</p> <p>1. During clinical record review on 6/17/14 at 9:30 a.m., Resident (G ) was admitted to the facility on 3/13/14. During review of the current immunization record, Resident (G) did not receive a 1st step tuberculin skin test or risk assessment until 3/19/14. The second skin tuberculin test was given on 4/7/14.</p> <p>During an interview on 6/17/14 at 1:30 p.m., the Corporate Nurse indicated</p>	R000408	The facility is unable to correct the alleged deficient practice for resident G regarding tuberculin skin test.All residents have the potential to be affected by the alleged deficient practice.The facility will conduct an audit on all assisted living residents for the last 30 days to ensure no other resident has been affected by the alleged deficient practice of not administering tuberculin upon admission.All nursing staff will be inserviced regarding tuberculin administration.Unit Manager will audit all new admits to ensure tuberculin administered with every admit the next business day, ongoing.DON/designee to review tuberculin audit monthly.QA committee to review results quarterly ongoing.	07/17/2014			

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	<p>Resident (G) did not receive a tuberculin skin test on admission. She was unsure why the resident did not receive the test on admission.</p> <p>No additional information was provided related to tuberculin skin tests.</p>				