

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/07/2011
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NAME OF PROVIDER OR SUPPLIER MAPLES AT WATERFORD CROSSING HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN46526
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F0000	<p>This visit was for the Investigation of Complaint IN00099960.</p> <p>Complaint IN00099960 - Substantiated. Federal/State deficiencies related to the allegation are cited at F282, F312 and F514.</p> <p>Survey dates: 12/6-7/11</p> <p>Facility number: 011150 Provider number: 155760 AIM number: 200831020</p> <p>Survey team: Ellen Ruppel, RN</p> <p>Census bed type: SNF: 40 SNF/NF: 17 Total: 57</p> <p>Census payor type: Medicare: 21 Medicaid: 14 Other: 22 Total: 57</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>This Addendum to the Plan of Correction for Complaint IN00099960 constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. The Maples at Waterford Crossing Health Campus desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance was effective January 6, 2012. The Maples at Waterford Crossing Health Campus respectfully requests this Addendum and Plan of Correction be submitted as desk review for compliance for the deficiencies cited.</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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F0282 SS=D	<p>Quality review completed 12/12/11 by Jennie Bartelt, RN.</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interviews and record review, the facility failed to follow physician's orders for administration of medications for 2 of 3 residents in a sample of 5 whose records were reviewed for accuracy in medication administration. (Residents B and C)</p> <p>Findings include:</p> <p>1. During interview on the orientation tour on 12/6/11 at 9:00 a.m., LPN (Licensed Practical Nurse) #7 indicated Resident B had been admitted recently with a diagnosis of pneumonia.</p> <p>The clinical record of Resident B was reviewed on 12/6/11 at 9:20 a.m., and indicated the resident had been admitted on 11/30/11 at 1:45 p.m., with diagnoses including, but not limited to, congestive heart failure, stage three kidney disease, diabetes and pneumonia.</p>	F0282	<p>It is the expectation of this facility to provide for or arrange services for the residents by qualified persons in accordance with the resident's written plan of care to include but not limited to following physician's orders for administration of medications with accuracy. What corrective action will be done by the facility?</p> <p>Resident Medication Administration Records were audited regarding potential for missed medication doses. No missed medication doses were observed. How will the facility identify other residents having the potential to be effected by the same practice and what corrective action will be taken?</p> <p>Resident (#B) was assessed for adverse effects related to the alleged practice. Resident (#B) received the final dose of the ordered antibiotic on 12/06/2011 at 10:00 am completing the ordered regimen. Assessment of this resident revealed no adverse</p>	01/06/2012

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	<p>Admission orders included an order for azithromycin (an antibiotic) 250 mg, one tablet daily for five days.</p> <p>The Medication Administration Record (MAR) for December 2011 indicated the first dose, which was due on 12/1/11, had not been given. The reason on the back of the MAR indicated the azithromycin was not available for the first dose on 12/1/11.</p> <p>Observation of the medications in the drawer for Resident B on 12/6/11 at 9:30 a.m., indicated one tablet of azithromycin in the drawer. The MAR had been crossed out to indicate the medication had been completed on 12/5/11. This indicated only four doses had been given, rather than the five doses which the physician had ordered.</p> <p>Review of the Medication Error Report, completed on 12/6/11, and provided on 12/7/11 at 12:00 noon, indicated LPN #13 had not found the medication in the PIXIS system (emergency drug supply system) and had called the pharmacy, and two deliveries had been made on 12/1/11, but no azithromycin was in the deliveries. The report indicated the next shift had been told about the medication not being delivered. The MAR had not been corrected on 12/1/11 to ensure the</p>		<p>effects for this resident. Documentation of the event was entered in the resident record. The resident's responsible party and physician were notified. (LPN #7) received re-education regarding guidelines for Medication Administration (Open Med Pass) and accuracy in medication administration. (LPN#7) received coaching and counseling and redirection to Medication Administration best practice. Resident (#C) was assessed for adverse effects related to the alleged practice. Assessment of this resident revealed no adverse effects for this resident. Documentation of the event was entered in the resident record. The resident's responsible party and physician were notified. (LPN #13) received re-education regarding guidelines for Medication Administration (Open Med Pass) and accuracy in medication administration. (LPN#13) received coaching and counseling and redirection to Medication Administration best practice. What measures will be put into place to ensure this practice does not recur? Licensed nurses including (LPN#7 and LPN#13) received re-education related to Medication Administration including but not limited to: Medication Administration guidelines (Open Med Pass), Pharmacy notification (Med delivery). Re-education and</p>		

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	<p>medication would be given for five days. The final dose was given on 12/6/11 at 10:00 a.m., with the resident having "missed" the initial dose on 12/1/11.</p> <p>2. The clinical record of Resident C was reviewed on 12/6/11 at 10:00 a.m. The record indicated the resident had been admitted to the facility on 11/20/11, with diagnoses including, but not limited to, urinary tract infection, gastroesophageal reflux and chronic pancreatitis.</p> <p>Physician's orders, dated 11/30/11, indicated the resident was to be given metoclopramide 10 mg (an antiemetic), morphine sulfate 15 mg (a narcotic pain medication) and Sotalolol 40 mg (for heart arrhythmia) before breakfast.</p> <p>Review of the MAR on 12/6/11 at 10:00 a.m., indicated the medications had not been signed as given, and the resident had eaten breakfast.</p> <p>The Medication Error Report was provided by the DON on 12/7/11 at 12:00 noon and indicated the nurse who had failed to give the medications had been counseled regarding the failure to give the medications as ordered.</p> <p>This federal tag relates to Complaint IN00099960.</p>		<p>training will be completed by: January 6, 2012 and ongoing. How will corrective action be monitored to ensure the deficit practice does not recur and what QA will be put into place? Nurse Managers and Medical Records will audit Medication Administration Records on each Community 5 times weekly for 30 days. <u>Consulting Pharmacist will assess nursing audit results monthly with recommendations.</u> Noncompliance greater than 3% will be reported to the Director of Health Services or (designee). Data will be analyzed and reported to QAA for review. QAA will direct further action or resolution. Completion date: 1/6/2012</p>				

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F0312 SS=D	<p>3.1-35(g)(2)</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on interviews and record review, the facility failed to ensure 1 resident in a sample of 5 received services to maintain personal hygiene. Resident E</p> <p>Findings include:</p> <p>The closed clinical record of Resident E was reviewed on 12/6/11 at 2:10 p.m., and indicated the resident had been admitted to the facility on 7/6/11, with diagnoses including, but not limited to, Parkinson's disease, aphasia and implanted brain stem stimulator.</p> <p>The five day Minimum Data Set (MDS)</p>	F0312	<p>It is the expectation of this facility to provide for our resident's who are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming and personal and oral hygiene. What corrective action will be done by the facility? Resident (#E) no longer lives in the campus. How will the facility identify other residents having the potential to be effected by the same practice and what corrective action will be taken? Documentation regarding bathing/hygiene was reviewed. No adverse effects observed regarding this alleged practice. What measures will be put into place to ensure this practice does not recur? Nursing</p>	01/06/2012	

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	<p>assessment, dated 7/13/11, indicated the resident was confused, in need of two staff members for extensive transfer assistance, totally dependent on one person for bathing and unsteady of balance. His initial assessment of daily routines, dated 7/6/11, indicated he preferred showers in the morning.</p> <p>Review of the shower/bath records for Resident E indicated one bed bath on 7/12/11 and one shower on 7/13/11, during the 14 days he was living in the facility. Partial baths had been recorded on 7/13, 7/15 and 7/17/11. There was no documentation to indicate he had refused showers, or that showers had been given at times other than specified on the bathing record. He had been discharged on 7/20/11.</p> <p>During an interview with a family member on 12/6/11 at 11:30 a.m., the family member indicated the family had been concerned about the number of showers given to Resident E during his stay in the facility.</p> <p>During an interview with the Director of Nursing (DON) on 12/7/11 at 11:30 a.m., he indicated the facility had no policy related to the specific number of showers/baths to be given, but the standard was for each resident to have two</p>		<p>staff will be re-educated regarding the guidelines for bathing/hygiene, Resident Preferences regarding bathing/hygiene, and documentation standards for bathing/hygiene. Re-eEducation and training will be completed by: January 6, 2012How will corrective action be monitored to ensure the deficit practice does not recur and what QA will be put into place?Nurse Managers/Medical Records will audit Bathing/Hygiene Records on each Community 5 times weekly for 30 days. <u>Nursing team consisting of Nurse Managers/Medical Records will interview 5% of the current census on each community focusing on bathing/hygiene.</u> Noncompliance greater than 3% will be reported to the Director of Health Services or (designee). Data will be analyzed and reported to QAA for review. QAA will direct further action or resolution. Completion date: 1/6/2012</p>		

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F0514 SS=D	<p>showers/baths a week.</p> <p>This federal tag relates to Complaint IN00099960.</p> <p>3.1-38(b)(2)</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interviews, the facility failed to maintain accurate and complete documentation regarding 1 resident in a sample of 5 whose records were reviewed for accuracy. (Resident E)</p> <p>Findings include:</p> <p>The closed clinical record of Resident E was reviewed on 12/6/11 at 2:10 p.m., and indicated the resident had been admitted to the facility on 7/6/11 and discharged on 7/20/11. The resident's diagnoses</p>	F0514	<p>It is the expectation of this facility to maintain accurate and complete documentation in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. What corrective action will be done by the facility? Resident (#E) no longer lives in the campus. How will the facility identify other residents having the potential to be effected by the same practice and what corrective action will be taken?</p>	01/06/2012	

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	<p>included, but were not limited to, hypertension, implanted brain stem stimulator and left retinal eye occlusion. The admission orders indicated the resident was allergic to Ativan (an anti anxiety medication).</p> <p>Nurses notes, dated 7/12/11 at 9:00 p.m. indicated, "PRN (as needed) Ativan D/T (due to) increased anxiety given per orders."</p> <p>The physician's orders and Medication Administration Record (MAR) indicated no order for the Ativan and no documentation on the MAR to indicate the medication had been given.</p> <p>LPN #3 checked with pharmacy and on 12/7/11 at 1:30 p.m. provided information indicating no Ativan had been sent for Resident E and none had been taken from the PIXIS (emergency drug system) for Resident E.</p> <p>The nurse (LPN #9) who had written the note of 7/12/11 was interviewed on 12/7/11 at 9:05 a.m. She indicated she had not given Resident E any Ativan, and had written the note in the wrong chart. She was unable to remember which resident had been given the Ativan five months ago.</p>		<p>Documentation from PCA Pharmacy revealed no Ativan dispensed from the Pyxis on the alleged date for any resident by (LPN#9) or any other licensed nurse in the campus on that date. Documentation from PCA Pharmacy revealed the Ativan alleged to be administered on 07/12/2011 was not dispensed to any resident. What measures will be put into place to ensure this practice does not recur? Nursing staff will be re-educated regarding the Medication Administration (Open Med Pass) guideline documentation standards. How will corrective action be monitored to ensure the deficit practice does not recur and what QA will be put into place? Nurse Managers/Medical Records will audit Medication Administration Records 5 times weekly for 30 days. <u>The Consulting Pharmacist will assess nursing audit results monthly with recommendations.</u> Noncompliance greater than 3% will be reported to the Director of Health Services or (designee). Data will be analyzed and reported to QAA for review. QAA will direct further action or resolution. Completion date: 1/6/2012</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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