

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155690	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2015
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NAME OF PROVIDER OR SUPPLIER  LINDBERG CROSSING SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00176047.</p> <p>Complaint IN00176047 - Substantiated. Federal/state deficiency related to allegation are cited at F309 and F329. Unrelated deficiencies are cited.</p> <p>Survey dates: 6/30-7/1/15</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Census bed type: SNF/NF: 44 Total: 44</p> <p>Census payor type: Medicare: 5 Medicaid: 32 Other: 7 Total: 44</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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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F 0309 SS=G Bldg. 00	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 a referral appointment was made following a physician's order for 1 of 3 residents reviewed. This failure resulted in a hospitalization for acute renal failure (Resident B). The facility also failed to ensure a resident received a pre-dialysis assessment and fistula monitoring for 1 of 1 residents reviewed for dialysis. (Resident C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 6/30/15 at 10:10 a.m. Diagnoses for the resident included, but were not limited to, chronic obstructive pulmonary disease, depression, obesity, congestive heart failure and chronic hypercapnic respiratory failure.</p> <p>Review of the laboratory results obtained on 4/20/15 indicated Resident B had a recorded Basic Urea Nitrogen (BUN) of</p>	F 0309	<p>F309</p> <p>1. Resident B has Nephrology appointments scheduled. Resident C's chart was reviewed, MD notified and orders received for fistula checks every Shift, and post dialysis assessments to be completed.</p> <p>2. There are currently no other residents receiving dialysis at this time. Resident C's Chart was reviewed. A chart audit was completed for all residents with ordered referral appointments. No other appointments were found to be missed. All licensed nursing staff were re-educated on the policy and procedure for dialysis care, including but not limited to the importance of Post dialysis assessment, and fistula assessment, and assuring physician ordered referral appointments are scheduled timely.</p> <p>3. As a means to ensure referral appointments are scheduled following a physician's order, post dialysis assessments, and fistula checks for residents receiving dialysis are completed, Licensed nursing staff</p>	07/31/2015
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	<p>37 mg/dL. The normal range for BUN was 7-25 mg/dL. He also had a creatinine result of 2.3 mg/dL. The normal range for creatinine was 0.6-1.3 mg/dL. A note on the laboratory test indicated for the facility was to obtain a nephrology consult for Resident B.</p> <p>Review of a Physician's order, dated 4/21/15, indicated a signed order for a nephrology consult.</p> <p>A Nursing note, dated 6/5/15 at 9:25 a.m., indicated Resident B was found in his room, pale and confused. Resident B had a pulse rate of 30 beats per minute. Other vital signs included; blood pressure 90/46, respiratory rate 22 and oxygen saturation 88%. Resident B was complaining of chest pain and nausea. 911 was called and Resident B was transferred to a local hospital.</p> <p>A Nursing note, dated 6/5/15 at 10:45 a.m., indicated a family member called the facility and stated Resident B's kidney were not functioning properly and he was sent to another hospital.</p> <p>During an interview on 6/30/15 at 1:45 p.m., the Director of Nursing (DON) indicated the staff person who receives a physician 's order, is the person who schedules the appointment. She</p>		<p>were re-educated on the policy and procedure for dialysis care, including but not limited to the importance of Post dialysis assessment, and fistula assessment, and assuring physician ordered referral appointments are made timely. The DON and/or her designee will monitor physician orders daily on scheduled days of work to assure residents with physician ordered referral appointments are scheduled in a timely manner. All Residents receiving dialysis, post dialysis assessments as well as fistula assessment will be monitored 5x/week x 1 month then 3x/week x 1 month then weekly thereafter, should concerns be noted, corrective action shall be taken.</p> <p>4. As a means of quality assurance, the DON and/or designee will report findings of the above reviews and any corrective actions taken to the QA committee monthly x 3 months and quarterly thereafter and revisions made to the plan if warranted on the basis of compliance.</p> <p>5.7-31-15</p>	

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	<p>indicated the nurse who took the order for the nephrology consult for Resident B no longer worked at the facility. She indicated the facility did not have a just one person who schedules all the appointments.</p> <p>Resident B returned to the facility on 6/12/15. 2. Resident #C's record was reviewed on 6/30/15 at 9:00 a.m. Resident #C's current diagnoses included, but were not limited to, depression, dementia, bipolar, anxiety and end stage renal disease.</p> <p>The record indicated Resident #C went out for dialysis on Mondays, Wednesdays and Fridays, order dated 3/16/13.</p> <p>The Post Dialysis Assessment, dated from 4/1/15 through 6/30/15, indicated the following:</p> <p>The Post Dialysis Assessment was not documented for 4/3/15, 4/10/15, 4/17/15 and 4/24/15. No Post Dialysis Assessments for March, May and June 2015 documented. The Post Dialysis Assessment did not provide for assessment of the fistula site.</p> <p>Refusal by the resident documented on the Post Dialysis Assessment for 4/1/15, 4/8/15, 4/13/15, 4/15/15, 4/20/15, 4/22/14, 4/24/15 and 4/29/15. No Post Dialysis Assessments for March, May,</p>			

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	<p>and June 2015</p> <p>During an interview on 6/30/15 at 11:15 a.m., the Director of Nursing indicated the fistula assessment should have been ordered for all residents receiving dialysis. She indicated she did not know when the order for assessment "fell off" the re-writes. Review of the Medication Administration Records for March, April, May and June 2015 indicated no order for assessment of fistula pre or post dialysis. The Director of Nursing indicated she could not provide documentation that the fistula assessment had ever been done. No further information provided.</p> <p>The 10/2014, policy titled "Dialysis Coordination/Facility Services" was provided by the Director of Nursing on 6/30/15 at 10:55 a.m.</p> <p>"Purpose: To ensure effective communication between the facility and dialysis center providing service to the resident.</p> <p>Policy: Facility personnel will communicate with the outpatient dialysis center in an effort to ensure the resident is rendered necessary care and services for the provision and maintenance of dialysis services. Facility personnel will monitor the status of the resident receiving dialysis for potential</p>			

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	<p>complications. Review physician's orders for the resident receiving dialysis to confirm: Type of access site and location Orders for care or access site, if any specified Dialysis days Order for provision of medications (meds [medications] to be held on dialysis days, provision of medications that will be missed during dialysis and meds to be given with meals) Frequency resident weight to be obtained If fluid restriction is ordered, ensure to follow policy regarding Fluid restrictions addressing fluids to be provided by nursing and by dietary. Procedure: ... 3. If dialysis facility requires form(s) to be filled out and sent with resident , complete and send with resident...."</p> <p>Review of a current facility policy dated 10/20/14, titled "PHYSICIAN ORDERS", which was provided by the Director of Nursing on 7/1/15 at 11:42 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe.</p>			

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F 0329 SS=D Bldg. 00	<p><b>POLICY:</b> Facility nursing personnel will ensure clear, accurate and complete physician's orders.</p> <p><b>PROCEDURE:</b> <b>TELEPHONE OR VERBAL ORDERS:</b> ...4. Notify the resident/legal representative of the new order and document notification in the clinical record. 5. Transcribe new order onto the MAR or TAR, as indicated. Ensure any follow through is completed."</p> <p>This Federal tag relates to Complaint IN00176047.</p> <p>3.1-37(a)</p> <p>483.25(l) <b>DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b> Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p>			

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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the correct amount of insulin was given per the physician's order for 1 of 3 residents reviewed for unnecessary medications. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's record was reviewed on 6/30/15 at 9:00 a.m. Resident #C's current diagnoses included, but were not limited to, depression, dementia, bipolar disorder, anxiety and end stage renal disease.</p> <p>Resident #C had an order, dated 4/30/12, for "Novolog Sliding Scale: 0-120 = 0 units, 121-150 = 2 units, 151-200 = 4 units, 201-250 = 6 units, 251-300 = 8 units, 301-350 = 10 units, 351-400 = 12 units, 401 or &gt;=15 units, recheck in 2 hours. Call MD for blood sugar &lt;60 or &gt; 400."</p>	F 0329	<p>F329</p> <p>1. Resident C's record was reviewed. Physician notified of the wrong dosages of insulin and the missed insulin coverage, with no new orders at this time.</p> <p>2. A chart review was conducted for all other residents receiving sliding scale insulin coverage. Physicians notified of any further abnormalities. All licensed nursing staff were re-educated on the policy and procedure regarding Charting and Documentation including but not limited to blood glucose monitoring and including but not limited to proper dosage and missed blood sugar readings and insulin coverage.</p> <p>3. As a means to ensure compliance with proper administration and documentation of insulin per sliding scale, all licensed nursing staff were re-educated on the policy and procedure regarding Charting and Documentation including but not limited to blood glucose monitoring including but</p>	07/31/2015

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	<p>Review of the Blood Glucose Monitoring Sliding Scale Insulin Record for March, April, May and June 2015, indicated the following:</p> <p>3/5/15 at 9:00 p.m. blood sugar 127 received 0 units, ordered 2 units.</p> <p>3/6/15 at 9:00 p.m. blood sugar 276 received 4 units, ordered 8 units.</p> <p>3/23/15 at 6:00 a.m. blood sugar 124 received 0 units, ordered 2 units.</p> <p>3/25/15 at 5:00 p.m. No documentation.</p> <p>4/7/15 at 6:00 a.m. blood sugar 54, no physician notification documented.</p> <p>4/17/15 at 12:00 p.m. blood sugar 222 received 4 units, ordered 6 units.</p> <p>4/19/15 at 12:00 p.m. No documentation.</p> <p>4/25/15 at 6:00 a.m. blood sugar 68 received 6 units, ordered 0 units.</p> <p>4/26/15 at 6:00 a.m. blood sugar 114 received 6 u nits, ordered 0 units.</p> <p>4/27/15 at 12:00 p.m. blood sugar 269 received 6 units, ordered 8 units.</p> <p>5/10/15 at 12:00 p.m. blood sugar 134 received 0 units, ordered 2 units.</p> <p>5/13/15 at 4:00 p.m. blood sugar 251 received 6 units, ordered 8 units.</p> <p>5/13/15 at 9:00 p.m. blood sugar 140 received 0 units, ordered 2 units.</p> <p>5/16/15 at 6:00 a.m. No documentation.</p> <p>5/16/15 at 8:00 p.m. blood sugar 183 received 2 units, ordered 4 units.</p> <p>5/17/15 at 6:00 a.m. No documentation.</p> <p>5/22/15 at 9:00 p.m. blood sugar 124</p>		<p>not limited to proper dosage and missed blood sugar readings and insulin coverage. The DON and/or designee will monitor resident care records for compliance 5x/week x 1 month, 3x/week x 1 month and weekly thereafter, should concerns be noted, corrective action shall be taken.</p> <p>4. As a means of quality assurance, the DON and/or designee will report the findings of the above reviews and any corrective actions to the QA committee meeting monthly x 3 months and quarterly thereafter, and revisions made to the plan, if warranted on the basis of compliance.</p> <p>5.7-31-15</p>	

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	<p>received 0 units, ordered 2 units. 6/10/15 at 9:00 p.m. blood sugar 140 received 0 units, ordered 2 units.</p> <p>During an interview on 7/1/2015 at 11:56 a.m., the Director of Nursing reviewed Resident's #C's clinical record. The Director of Nursing indicated she had no information regarding the doses of insulin given on the previously mentioned dates. She indicated the facility had a plan in place to review the Blood Glucose Monitoring Sheets, however the plan was not followed and the errors were not discovered. She also indicated the facility had began implementing the plan approximately 6 weeks ago.</p> <p>Review of the current facility policy, dated 10/2014, titled "Medication Administration ", provided by the Director of Nursing on 7/1/15 at 11:17 a.m., included, but was not limited to, the following:</p> <p>"Purpose: To safely administer medications as per physicians' orders. ...10. Always observe the six rights of giving each medication. RIGHT RESIDENT RIGHT MEDICINE RIGHT TIME RIGHT DOSE</p>			

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F 0502 SS=D Bldg. 00	<p>RIGHT ROUTINE RIGHT DOCUMENTATION...."</p> <p>This Federal tag relates to Complaint IN00176047.</p> <p>3.1-48(s)(4)</p> <p>483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure labs were completed for 1 of 3 residents reviewed for laboratory orders. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 6/30/15 at 3:00 p.m. Diagnoses for the resident included, but were not limited to, chronic airway obstruction, congestive heart failure, episodic mood disorder, depression, anxiety and diabetes mellitus.</p> <p>On 6/5/15, a Physician's orders indicated to obtain urine for UA [urinalysis] with C &amp; S [culture and sensitivity] if indicated.</p>	F 0502	<p>F502</p> <p>1. Resident D's physician was notified of the missed UA. No new orders received as she just returned from hospital stay.</p> <p>2. A chart review was conducted for all ordered labs to assure no further missed labs. Any noted inconsistencies were reported to the physicians with orders obtained, if pertinent. All licensed nursing staff were re-educated on the policy and procedure for laboratory orders, including but not limited to assuring follow through.</p> <p>3. As a means to ensure compliance with property follow through with laboratory orders, licensed nursing staff were re-educated on the policy and procedure for laboratory orders, including but not limited to</p>	07/31/2015

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	<p>A review of the labs completed for Resident D indicated no urinalysis was completed for the 6/5/15 order.</p> <p>Resident D's Health Care Plan, dated 6/24/15, indicated, "The resident is occasionally incontinent of urine due to ...diuretic use...DM [diabetes mellitus]." Interventions included, but were not limited to, monitor for signs and symptoms of infection such as: elevated temperature, pain, swelling, foul smelling urine, cloudy urine and notify the charge nurse of any problems for further evaluation and possible MD and responsible party notification.</p> <p>During an interview with the Director of Nursing on 7/1/15 at 9:10 a.m., she indicated they were unable to find any labs completed for 6/5/15.</p> <p>Review of a current facility policy, dated 10/20/14, titled "PHYSICIAN ORDERS", which was provided by the Director of Nursing on 7/1/15 at 11:42 a.m., included, but was not limited to, the following:</p> <p>"PURPOSE: Physician's orders are administered upon the clear, complete and signed order of an individual lawfully authorized to prescribe.</p>		<p>assuring follow through. The DON and/or designee will monitor lab physician ordered labs 5x/week x 1 month, 3x/week x 1 month and weekly thereafter to assure no physician orderedlabs are missed, should convers be noted, corrective action shall be taken.</p> <p>4.As a means of quality assurance, theDON and/or designee will report the findings of the above reviews and anycorrective actions to the QA committee meeting monthly x 3 months and quarterlythereafter, and revisions made to the plan, if warranted on the basis ofcompliance.</p> <p>5.7-31-15</p>	

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F 0514 SS=D Bldg. 00	<p><b>POLICY:</b> Facility nursing personnel will ensure clear, accurate and complete physician's orders.</p> <p><b>PROCEDURE:</b> <b>TELEPHONE OR VERBAL ORDERS:</b> ...4. Notify the resident/legal representative of the new order and document notification in the clinical record. 5. Transcribe new order onto the MAR or TAR, as indicated. Ensure any follow through is completed."</p> <p>This Federal tag relates to Complaint IN00176047.</p> <p>3.1-49(a)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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</p>			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155690	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  07/01/2015
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NAME OF PROVIDER OR SUPPLIER  LINDBERG CROSSING SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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	<p>care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident records were complete and accurate in regard for 1 of 3 residents reviewed for complete and accurate records. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 6/30/15 at 3:00 p.m. Diagnoses for the resident included, but were not limited to, chronic airway obstruction, congestive heart failure, episodic mood disorder, depression, anxiety and diabetes mellitus.</p> <p>A health care plan problem, dated 6/24/15, indicated Resident D had a problem with diabetes mellitus and at risk for experiencing hypoglycemia and hyperglycemia. One of the approaches for the problem included, but was not limited to, "document the results of the blood glucose tests, notification of the MD, responsible party...."</p> <p>Review of the Physician orders for June, indicated the following: "BS [blood sugar] &lt; [less than] 60 mg/dL or &gt;[greater than] 400 mg/dL repeat</p>	F 0514	<p>F514</p> <p>1. Resident D was not affected by the incomplete documentation of her blood sugar readings in the clinical record.</p> <p>2. A chart review was completed to assure records contained complete and accurate records of blood sugar readings per physicians order. Licensed nursing staff were re-educated on complete and accurate documentation of blood sugar readings in the clinical record.</p> <p>3. As a means to ensure compliance with complete and accurate records of blood sugar readings, licensed nursing staff were re-educated on complete and accurate documentation of blood sugar readings in the clinical record. The DON and/or designee will monitor all blood glucose monitoring records to assure complete and accurate documentation in the clinical record 5x/week x 1 month, 3x/week x 1 month, and weekly thereafter, should concerns be noted, corrective actions shall be taken.</p> <p>4. As a means of quality assurance, the DON and/or designee will report the findings of the above reviews and any corrective actions to the QA meeting monthly 3 months and</p>	07/31/2015

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	<p>accuchecks in 2 hours. If BS has not come down, notify MD."</p> <p>Review of the Blood Glucose Monitoring Sliding Scale Insulin Record for 4/2015 through 5/20/15 indicated Resident D had a blood glucose level of 427 mg/dL on 4/17/15 at 4:00 p.m. Resident D was given 6 Units of Novolog.</p> <p>On 5/9/15 at 11:30 a.m., Resident D had a blood glucose level of 440 mg/dL. She was given 6 Units of Novolog.</p> <p>On 5/22/15 at 12:00 p.m., Resident D had a blood glucose level of 426 mg/dL. She was given 6 Units of Novolog.</p> <p>On 5/23/15 at 12:00 p.m., Resident D had a blood glucose level of 446 mg/dL. She was given 6 units of Novolog.</p> <p>Review of the April and May nursing notes indicated no staff person documented the glucose levels or any re-check levels.</p> <p>During an interview on 7/1/15 at 11:18 a.m., the Director of Nursing (DON) indicated the staff were documenting on the 24 hour report sheet, but not in the clinical chart. She indicated the 24 hour report was not part of the clinical record and she kept the information from survey</p>		<p>quarterly thereafter, and revisions made to the plan if warranted on the basis of compliance. 5.7-31-15</p>	

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	to survey.  This Federal tag relates to Complaint IN00176047.  3.1-50(a)(1)(2)				