

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/09/2015
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NAME OF PROVIDER OR SUPPLIER BLOOM AT GERMAN CHURCH	STREET ADDRESS, CITY, STATE, ZIP CODE 2250 HARVEST MOON DR INDIANAPOLIS, IN 46229
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00177078.</p> <p>Complaint IN00177078 - Substantiated. State deficiencies are cited at R240.</p> <p>Date of Survey: July 8 and 9, 2015</p> <p>Facility number: 0003916 Provider number: 0003916 AIM number: N/A</p> <p>Census bed type: Residential: 58 Total: 58</p> <p>Census Payor Type: Medicaid: 36 Private: 22 Total: 58</p> <p>Sample: 9</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>Submission of this response and Plan of Correction is not a legal admission that the deficiency exists or, that the Statement of the Deficiencies was correctly cited, and is also not to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of the facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</p>	
R 0217	410 IAC 16.2-5-2(e)(1-5)			

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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Bldg. 00	<p>Evaluation - Deficiency</p> <p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope; (B) frequency; (C) need; and (D) preference; of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to update a service plan for 1 of 6 residents' service plans reviewed. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 7/8/15 at 1:00 p.m. The</p>	R 0217	<p>Citation #1 R 217 410 IAC 16.2-5-2(e)(1-5) Evaluation-Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #B's service plan will be updated upon readmission to Bloom at German Church. Resident B's service</p>	07/28/2015
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	<p>diagnoses included, but were not limited to, osteopenia, pain, history of falls (8/7/14, 9/11/14, 4/20/15, 5/24/15, 5/30/15) and right rib fracture.</p> <p>A Service Plan dated, 4/15/15, indicated Resident #B required no assistance with mobility or transfers.</p> <p>Physical therapy visit notes dated, 4/27/15, 4/29/15, 5/4/15, 5/14/15, 5/15/15, 5/19/15, 5/20/15, 5/25/15, 6/1/15, 6/3/25 and 6/25/15 indicated Resident #B's functional limitations and problem areas were the following: range of motion/strength, safety techniques, balance/gait, transfer, pain, and increased fall risk.</p> <p>An interview was conducted on 7/9/15 at 11:30 a.m. with physical therapist #4. She indicated Resident #B needed 1 person assistance with transfers and her assistance varied day by day on how much assistance she needed. Physical therapist #4 indicated she used a gait belt during therapy to assist Resident #B during transfers or "contact guard assist" (minimal assistance).</p> <p>An interview was conducted on 7/9/15 at 11:45 a.m. with the Director of Wellness. She indicated Resident #B's service plan had not been updated indicating Resident</p>		<p>plan will be reevaluated again within 30 days of initial readmission or sooner if a significant change is noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective answers will be taken? The Wellness Director and/or Designee will conduct a review of current residents to ensure compliance with the above referenced citation. If any concerns are noted the Wellness Director and/or Designee will immediately update the service plan. This review will be completed by July 28th 2015. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not occur? The Executive Director and Wellness Director and /or Designee were reeducated to Bloom at German Church Policy and Procedure regarding resident service assessment. Wellness Director and/or Designee will be responsible for ensuring service plans are accurate and updated with Bloom at German Church Policy and Procedure to ensure continued compliance with Indiana State Department of Health Regulation R 217 410 IAC16.2-5-2(e)(1-5) Evaluation How will the corrective action(s) be monitored to ensure the deficient practice</p>				

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R 0240 Bldg. 00	<p>#B needed assistance after her fall on April 20th.</p> <p>A service plan policy dated, May 2012, indicated the following: "Policy: A resident service assessment should be completed for each resident to determine his/her service needs and the related price for the services. Once the service needs are determined, specifics of the services required should be documented in the resident's service plan. Procedure: 1...The community shall reassess resident's service level thirty (30) days after move-in and quarterly thereafter or at any time resident's condition changes..."</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on observation, interview and record review, the facility failed to ensure appropriate transfer techniques were followed for 2 of 4 residents reviewed for assistance in transferring. (Resident #B and Resident #E)</p>	R 0240	<p>will not recur? i.e. What quality assurance program will be put into place? The Wellness Director and/or Designee will perform weekly audits beginning the week of 8-03-2015 (10 percent of service plans) weekly for four week, then monthly audits (10 percent of service plans) for two months, and then quarterly audits (10 percent of service plans) for three quarters. Any issues identified will be corrected immediately. By what date will the systemic changes be completed? July 28th 2015</p> <p>Citation #2 R 240 410 IAC 16.2-5-4(d) Health Services-Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #B's will be evaluated by PT and OT therapy</p>	07/28/2015			

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	<p>Findings include:</p> <p>1. The clinical record for Resident #B was reviewed on 7/8/15 at 1:00 p.m. The diagnoses included, but were not limited to, osteopenia, pain, history of falls (8/7/14, 9/11/14, 4/20/15, 5/24/15, 5/30/15) and right rib fracture.</p> <p>Physical therapy visit notes dated, 4/27/15, 4/29/15, 5/4/15, 5/14/15, 5/15/15, 5/19/15, 5/20/15, 5/25/15, 6/1/15, 6/3/25 and 6/25/15 indicated Resident #B's functional limitations and problem areas were the following: range of motion/strength, safety techniques, balance/gait, transfer, pain, and increased fall risk.</p> <p>A document from an incident report dated, 6/24/15, indicated CNA #3 transferred Resident #B by holding her upper arms during a transfer from the bed to the chair. CNA #3 indicated she was trying to find another way to help transfer Resident #B, because Resident #B indicated transferring by lifting under her arms had hurt.</p> <p>A document from an incident report dated, 6/28/15, indicated Resident #B had informed staff not to use her shoulders when putting her to bed, because it hurt.</p>		<p>upon readmission. Therapy will give recommendations regarding safe transfer techniques to the Director of Wellness or Designee with additional all staff in-servicing if applicable. Resident # E will be evaluated by her current Hospice provider to determine safe transfer techniques. The Hospice provider will give recommendations regarding safe transfer techniques to the Director of Wellness or Designee with additional all staff in-servicing if applicable. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective answers will be taken? The Wellness Director and/or Designee in conjunction with Home Health Therapy Providers will conduct a review of all current residents to ensure compliance with the above referenced citation. The therapy providers will present an all staff in-service on July 27th that will include proper transfer technique and gait belt use. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not occur? In-servicing will be completed on or before July 27th to include Bloom at German Church Policy and Procedure regarding "Lifting and Transferring a Resident" Included in the in-service will be gait belt</p>				

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	<p>An interview was conducted on 7/8/15 at 2:45 p.m., with the Director of Wellness. She indicated staff had been transferring Resident #B by "bear hugging" (wrapping both arms around the back). The staff had not been using a gait belt during transfers with Resident #B.</p> <p>An interview was conducted on 7/9/15 at 11:30 a.m., with physical therapist #4. She indicated Resident #B needed 1 person assistance with transfers and her assistance varied day by day on how much assistance she needed. Physical therapist #4 indicated she used "contact guard assist" (minimal assistance) or a gait belt to assist Resident #B during transfers. Resident #B had no complaints with the use of a gait belt.</p> <p>A policy titled, "Wellness", dated May 2012, provided by Executive Director on 7/9/15 at 8:30 a.m. It indicated the following: "Subject: Lifting and Transferring a Resident Policy: ...1. Residents should receive assistance with mobility and transferring as needed. The level of assistance is determined by the most recent assessment and may be in consultation with a physical therapist or other clinician. A transfer belt should be used to ensure the safety of the resident and the associate who is assisting during a transfer...2. Transfer belts, such as gait</p>		<p>use and safe practices. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? i.e. What quality assurance program will be put into place? The Wellness Director and/or Designee will perform random audits(20 percent) beginning the week of 7-27-2015 weekly for four weeks (lifting,transferring and gait belt use), then monthly audits for two months (lifting,transferring and gait belt use), and then quarterly audits for three quarters(lifting, transferring and gait belt use). Any issues identified will be corrected immediately. By what date will the systemic changes be completed? July 28th 2015</p>	

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	<p>belts and walking belts, are used when the resident's ability to move has decreased. Examples may include, but not be limited to:...General weakness due to an illness...A fall has occurred and requires emergency attention.</p> <p>Procedure:...2. Document the need for transfer assistance and use of transfer belt in the resident record. Update the resident's service assessment and resident's service plan...</p> <p>2. During an observation on 7/9/15 at 11:45 a.m., QMA #2 and LPN #1 were observed transferring Resident #E from her bed to her wheelchair. QMA#2 locked the wheels of the wheelchair after she positioned it next to the bed. QMA#2 attempted to lift Resident #E from her bed by putting her hand under Resident #E's left armpit and holding the back of Resident #E's pants. Resident #E was unable to provide any assistance and was not able to bear weight on her legs. QMA #2 lowered Resident #E back down to the bed and repositioned the wheelchair in front of the resident, facing the bed. QMA #2 put her hand under Resident #E's left armpit and held the back of Resident #E's pants, while LPN #1 put her hand under Resident #E's right armpit. Resident #E was assisted to a standing position and Resident #E grabbed the wheelchair handrails and</p>			

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	<p>pivoted herself around, while QMA#2 and LPN #1 were holding Resident #E under her armpits. Resident #E was then assisted to a seated position in the wheelchair. QMA #2 held on to the back of Resident #E's pants during the entire transfer.</p> <p>During an interview with QMA #2, on 7/9/15 at 11:55 a.m., QMA #2 indicated a gait belt was only needed when there was only 1 person to assist, but since there was two people assisting with the transfer, a gait belt was not needed.</p> <p>A Service Plan, dated 6/23/15, indicated Resident #E needed physical assist with all transfers.</p> <p>A IDT Care Plan, dated 5/21/15, indicated Resident #E was a high risk for falls.</p> <p>A policy titled, Wellness...Lifting and Transferring a Resident, dated 5/2012, was received from the Administrator on 7/9/15 at 8:30 a.m. The policy indicated, "1. Residents should receive assistance with mobility and transferring as needed....A Transfer Belt should be used to ensure the safety of the resident and the associate who is assisting during a transfer....Transfer belts, such as Gait Belts and Walking Belts, are used when</p>			

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R 0241 Bldg. 00	<p>the resident's ability to move has decreased...."</p> <p>During an interview with the Wellness Director, on 7/9/15 at 12:27 p.m., the Wellness Director indicated a gait belt should have been used during the above observation, according to the policy.</p> <p>This State Tag relates to Complaint #IN00177078.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview, and record review, the facility failed to administer insulin as ordered by a Resident ' s Physician for 1 of 2 residents reviewed for insulin administration. (Resident #45).</p> <p>Findings include:</p> <p>During an observation, on 7/8/15 at 12:14 p.m., LPN #1 was observed drawing up Humalog (insulin) in a insulin syringe in the Nurse's Station/Room for Resident</p>	R 0241	Citation #3 R 241 410 IAC 16.2-5-4(e)(1) Health Services-Offense What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #45's medical record was reviewed by Wellness Director. Young at Heart Pharmacy was notified and asked to provide information regarding insulin administration for nursing staff to review. All licensed nursing staff will be in-serviced on or before July 27th 2015 in regards to insulin administration	07/28/2015

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	<p>#45. LPN #1 replaced the cap on the syringe and placed the syringe in a syringe wrapper/packaging with the name of Resident #45, Humalog, and 5 units written on it. LPN #1 then proceeded to the Main Dining Room.</p> <p>During an interview with LPN #1, on 7/8/15 at 12:16 p.m., LPN #1 indicated Resident #45 was to receive 5 units of Humalog.</p> <p>At 12:19 p.m., on 7/8/15, LPN #1 wheeled Resident #45 from the Main Dining Room to Resident #45's room. The syringe filled with Humalog was observed to be filled to the line that indicated 6 units were in the syringe. Resident #45 lifted her shirt for the administration of the insulin syringe to the abdomen. LPN #1 asked Resident #45 if she was ready for the administration of the insulin and Resident #45 indicated she was ready for the medication. LPN #1 was questioned how many units were in the syringe and LPN #1 was then observed holding the syringe up and pushing the syringe plunger to release the insulin out of the syringe. Visible clear liquid was observed coming out of the syringe at this time. LPN #1 then administered the insulin to Resident #45, in her abdomen.</p>		<p>and Bloom at German Church Policy and Procedure for Medicine Administration. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? The Wellness Director and/or Designee will review medical records of all insulin dependent residents, to include current insulin orders and blood sugars since July 1st, 2015. If any irregularities are revealed the primary care physician will be notified and one on one education will be provided to the licensed staff involved by the Wellness Director or Designee. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not occur? In-servicing will be completed on or before July 27th to include Bloom at German Church Policy and Procedure "Wellness...Medications", insulin administration, and following physician orders. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? i.e. What quality assurance program will be put into place? The Wellness Director and/or Designee will perform random audits(20 percent)weekly for four weeks, monthly for two months, then</p>	

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	<p>On 7/8/15 at 12:29 p.m., LPN #1 indicated she pushed some insulin out of the syringe because the insulin was "right at the six line."</p> <p>A Physician Order indicated Resident #45 was to receive 5 units of Humalog at 12:00 p.m.</p> <p>A policy titled, Wellness...Medications, dated 5/2012, was received from the Administrator at 2:45 p.m., on 7/8/15. The policy indicated, "...It is the policy of [name of company] to supervise or administer all medications that the residents receive as ordered by their physician. [Name of company] provides appropriate methods and procedures for the obtaining, dispensing and administering of drugs approved by the Wellness Director and consulting Pharmacist...."</p>		<p>quarterly for three quarters of insulin dependent diabetics to ensure physician orders are followed according to Bloom at German Church's Policy and Procedure. Any issues identified will be corrected immediately. By what date will the systemic changes be completed? July 28th 2015</p>	