

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2011
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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN46953
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00100468.</p> <p>Complaint IN00100468, unsubstantiated due to lack of evidence.</p> <p>Survey dates: December 12, 13, 14, 15, 16, 2011.</p> <p>Facility number: 000186 Provider number: 155289 AIM number: 100266300</p> <p>Survey team: Delinda Easterly, RN TC Betty Retherford, RN Ginger McNamee, RN Karen Lewis, RN</p> <p>Census bed type: SNF/NF: 93 Total: 93</p> <p>Census payor type: Medicare: 19 Medicaid: 59 Other: 15 Total: 93</p>	F0000	In lieu of Survey results, the facility respectfully request review for potential paper compliance of the Plan of Correction submitted.	

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>Sample: Stage 2 Sample: 34</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 20, 2011 by Bev Faulkner, 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 record review and interview, the facility failed to ensure blood sugar monitoring was completed as ordered by the physician and insulin coverage was given when indicated for 1 of 10 residents reviewed for unnecessary medication use in a Stage 2 Sample of 34. (Resident #148)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #148 was reviewed on 12/14/11 at 11:00 a.m.</p>	F0282	Resident #148 physician was notified of the omitted documented blood sugars. All residents have the potential to be affected by the alleged deficient practice. Blood sugars for all residents have been audited for the last 30 days to ensure that no other resident has been effected by the alleged deficient practice and the Physician notified when applicable. Blood sugars to be audited each business day by the Unit Managers to ensure that the appropriate documentation has been completed. Audits to be reviewed by the DON/designee weekly to ensure all blood sugars have been documented appropriately. Audits to be	01/15/2012	

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	<p>Resident #148's current diagnoses included, but were not limited to, diabetes mellitus, hypertension, and pain.</p> <p>Resident #148 had physician's orders for the following:</p> <p>A. Levemir (insulin) inject 24 units subcutaneous every morning. The original date of this order was 11/8/11.</p> <p>B. Novolog (insulin) inject 10 units subcutaneous before meals. The original date of this order was 12/13/11.</p> <p>C. Monitor blood glucose levels before meals: 7:00 a.m., 11:00 a.m. and 4:30 p.m. The original date of this order was 9/15/11.</p> <p>D. Administer Novolog sliding scale insulin coverage based on blood glucose results according to the scale below,</p> <p>150 - 200 = 3 units 201 - 250 = 6 units 251 - 300 = 9 units 301 - 350 = 12 units 351 - 400 = 15 units 401 - = 15 units Recheck in 30 minutes, if remains</p>		<p>reviewed at the monthly QA Committee meeting for 12 months for continued compliance.</p>		

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	<p>above 400 call physician.</p> <p>A health care plan, dated 9/6/11, indicated Resident #148 had a problem listed as, the resident has diabetes mellitus. Interventions for this problem indicated the resident's blood glucose levels would be monitored and sliding scale insulin would be given when indicated based on the blood glucose results.</p> <p>Review of the October 2011 Medication Administration Record (MAR) for Resident #148 lacked documentation of the blood glucose result and amount of insulin given on the following dates and times:</p> <p>October 2, 4:30 p.m., no blood glucose result was documented and no insulin was documented as having been given.</p> <p>October 10, 11:00 a.m., no blood glucose result was documented and no insulin was documented as having been given.</p> <p>October 11, 11:00 a.m., no blood glucose result was documented and no insulin was documented as having been given.</p>				

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	<p>October 21, 11:00 a.m., no blood glucose result was documented and no insulin was documented as having been given.</p> <p>October 22, 11:00 a.m., no blood glucose result was documented and no insulin was documented as having been given.</p> <p>October 27, 4:30 p.m., no blood glucose result was documented and no insulin was documented as having been given.</p> <p>During an interview with the Director of Nursing (DoN) on 12/15/11 at 3:30 p.m., additional information was requested related to the lack of blood glucose results and sliding scale coverage having been documented as given if indicated on the dates and times noted above.</p> <p>During an interview with the DoN on 12/16/11 at 9:30 a.m., she indicated no additional documentation could be provided regarding the blood glucose and sliding scale coverage on the dates and times noted above.</p> <p>2.) Review of the current facility policy, dated 3/2005, titled "DIABETES MELLITUS-ROUTINE</p>				

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F0323 SS=D	<p>CARE," was provided by the Director of Nursing on 12/16/11 at 8:00 a.m., included, but was not limited to, the following:</p> <p>"Purpose:...3. To recognize, assist and document the treatment of complications commonly associated with diabetes.</p> <p>4. To provide care that will enable the resident to achieve and or maintain control of diabetes and to function safely in his/her natural environment...."</p> <p>3.1-35(g)(2)</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were not left unattended at the bedside for 1 resident in a Stage 2 Sample of 34. This had the potential to affect 2 residents residing in the room. (Resident #'s 83 and 136) (LPN # 2)</p> <p>Findings include:</p>	F0323	<p>The facility is unable to correct the alleged deficient practice for resident #83.All residents have the potential to be effected by the alleged deficient practice.LPN #2 has been individually re-educated regarding the "Medication Five Rights" facility policy. All additional Nurses to be in-serviced by the DON/designee regarding the facility's existing policy.DON/designee to observe medication pass weekly for 3</p>	01/15/2012	

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	<p>1.) During an observation on 12/12/11 at 4:06 p.m., LPN #2 was observed opening the door and entering Resident #83's room. Resident #83 was in bed and his roommate (Resident # 136) was up in his wheelchair. Resident #83's over the bed table was next to his bed and had two partially filled medication cups on it. The LPN indicated the medication cups contained Sinemet (a medication to treat Parkinson's disease) and Depakote Sprinkles (an anti-convulsant medication.) The Unit Manager #1 was present during the observation and indicated the medications should not have been left unattended at the bedside.</p> <p>2.) Resident #83's clinical record was reviewed on 12/16/11 at 9:00 a.m. The resident's diagnoses included, but were not limited to dysphasia oropharyngeal phase, hemiplegia/hemiparesis due to cerebrovascular disease, and cognitive deficits due to cerebrovascular disease.</p> <p>The resident had current signed physician's orders for Sinemet 25-100 milligrams three times a day and Depakote Sprinkles 125 milligrams two times a day. Both medications were scheduled to be administered at</p>		<p>months, twice monthly for 3 months, then monthly for 3 months. If no concerns are observed, then medication observations will be suspended depending upon QA Committee recommendations. Medication observation passes to be reviewed at QA Committee meetings monthly for 9 months and then medication observation passes to be suspended if no concerns identified.</p>		

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	<p>4:00 p.m.</p> <p>The resident had a 8/28/11, quarterly Minimum Data Set assessment. The assessment indicated the resident had short and long term memory problems.</p> <p>3.) Resident #136's clinical record was reviewed on 12/16/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, dementia and cerebrovascular accident.</p> <p>The resident had a 11/19/11, quarterly Minimum Data Set assessment. The assessment indicated the resident had short and long term memory problems.</p> <p>The resident had a care plan review on 11/18/11. The resident's care plan indicated there was a need for speech therapy related to cognitive/linguistic problems as evidenced by impaired cognition. The resident had another care plan problem of having a history of exhibiting inappropriate behavior as evidenced by wandering into others rooms.</p> <p>The undated "Medication Five Rights" policy was provided by the Director of Nursing on 12/16/11 at 8:00 a.m. The</p>				

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F0514 SS=D	<p>policy indicated medications were not to be left at the bedside.</p> <p>3.1-45(a)(1)</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 interview, the facility failed to ensure resident clinical records were complete and accurately documented for 2 of 10 residents reviewed for signed physician's orders and/or documentation of physician notification in a Stage 2 Sample of 34. (Resident #18 and #136)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #18 was reviewed 12/14/11 at 10:30 a.m.</p> <p>Diagnoses for Resident #18 included, but were not limited to, congestive heart failure, atrial fibrillation, and</p>	F0514	<p>The facility is unalbe to correct the alleged deficient practice of documented Physician notification in the resident's clinical record. Physician to be notified regarding the need to sign the current recapulation. All other residents have the potential to be affected by the alleged deficient practice. All resident's recapitulations have been audted to ensure that "recaps" have been signed timely. Medical Records to audit "recaps" monthly to ensure that timely signatures have been obtained ongoing. Nursing staff have been re-educated regarding the current faciltiy policy of "Documentation Procedures and Guidelines" by the DON/designee. Unit managers to audit all Physician ordered labs/tests for Physician</p>	01/15/2012	

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	<p>chronic airway obstruction.</p> <p>Resident #18 had a physician's order, dated 10/2/11, for Cleocin (an antibiotic) 150 mg four times daily for 7 days for a respiratory infection.</p> <p>A physician's order, dated 10/12/11, indicated the resident was to have a repeat chest x-ray in one week.</p> <p>A chest x-ray report, dated 10/20/11, indicated the resident continued to have a small right sided pleural effusion. The clinical record lacked documentation of physician notification of the abnormal chest x-ray report. The clinical record lacked documentation of any new orders related to the chest x-ray report.</p> <p>During an interview with Unit Manager #1 on 12/15/11 at 10:05 a.m., additional information was requested related to the lack of documentation of physician notification of the chest x-ray report.</p> <p>During an interview on 12/15/11 at 11:10 a.m., Unit Manager #1 provided a copy of a "Physician Notification Form" maintained by the nursing staff, dated 10/21/11, which indicated the physician had been notified of</p>		notification upon facility notification of results. Audits to be completed each business day to ensure that appropriate notifications and documentation have occurred. Unit Manager and Medical Records audits to be reviewed by the DON/designee weekly for any systematic concerns ongoing. QA committee to discuss audits monthly ongoing.		

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	<p>Resident #18's chest x-ray report and no new treatment was ordered. Unit Manager #1 indicated this form was not part of the resident's clinical record and the physician notification information should have been documented in the nursing notes.</p> <p>The last signed recapitulation (recap) of physician's orders in the resident's clinical record was dated 9/8/11. The clinical record contained progress notes written by the Nurse Practitioner dated 10/12/11 and 11/2/11.</p> <p>During an interview with Unit Manager #1 on 12/14/11 at 1:55 p.m., additional information was requested related to the lack of any signed recaps after 9/8/11.</p> <p>During an interview on 12/14/11 at 2:45 p.m., the Medical Records Designee indicated she had talked to the Nurse Practitioner and she had signed recaps during the visits noted above. The Medical Records Designee indicated she did not know why the signed recaps were not in the resident's clinical record and she had been unable to locate them in the resident's "thinned file." She indicated she had generated new recaps for those time periods and the Nurse Practitioner was present in the</p>				

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	<p>building and had signed them for placement in the clinical record.</p> <p>2.) The clinical record for Resident #136 was reviewed on 12/15/11 at 10:40 a.m.</p> <p>Diagnoses for Resident #136 included, but were not limited to, muscle weakness and aftercare for a healing hip fracture.</p> <p>A physician's order, dated 9/1/11, indicated Resident #136 was to have a urine specimen sent for urinalysis and culture and sensitivity related to concentrated urine with a foul order. A laboratory report, dated 9/1/11, indicated the specimen was sent for testing on that date and the final culture and sensitivity was completed on 9/3/11.</p> <p>The report indicated the urine was positive for methicillin resistant staphylococcus aureus and identified multiple antibiotics to which the organism was sensitive.</p> <p>The lab report and nursing notes lacked any information related to the physician having been contacted regarding the abnormal urine culture and sensitivity.</p>				

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	<p>During an interview with the Director of Nursing (DoN) on 12/15/11 at 1:20 p.m., additional information was requested related to the physician having been notified of the abnormal lab report.</p> <p>During an interview on 12/15/11 at 3:19 p.m., the Infection Control Nurse provided another copy of the laboratory report which indicated the physician had seen the laboratory report and had written "No new orders, low colony count." The Infection Control Nurse indicated this report had been in her infection control files which were not part of the clinical record. The notation on the report also lacked the date the notation was made by the physician.</p> <p>3.) Review of the current facility policy, dated 11/2010, titled "Documentation Procedures and Guidelines, provided by the DoN on 12/16/11 at 8:00 a.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>1. To reflect the quality of care provided to each resident....</p> <p>...Nursing Documentation:</p>				

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	<p>1.) Each health care professional shall be responsible for making their own prompt, factual, concise, entries that are complete, appropriate, and readable.</p> <p>2.) Each entry will include the date, time, signature, and position (title) of the individual making the entry.</p> <p>3.) Entries will be made whenever there is a change in the resident's condition. The entry will include interventions and appropriate notifications made in a timely manner.</p> <p>...7.) Verbal and telephone communication with all parties concerning the care and treatment of the resident will be entered in the clinical record...."</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				