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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 01/28/2016 |
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| NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256 |
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| F 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaints IN00190826, IN00191780 and IN00191862.</p> <p>Complaint IN00190826 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F387, F411 and F425.</p> <p>Complaint IN00191780 -- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00191862 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F225 and F226.</p> <p>Unrelated citation is cited.</p> <p>Survey dates: January 25, 26, 27 and 28, 2016</p> <p>Facility number: 013019 Provider number: 155815 AIM number: 201251520</p> <p>Census bed type: SNF: 54 SNF/NF: 10 Residential: 23 Total: 87</p> | F 0000 | <p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00190826, IN00191780 and IN00191862)) Survey on January 28, 2016.</p> <p>Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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| F 0157 SS=D Bldg. 00 | <p>Census payor type: Medicare: 39 Medicaid: 9 Other: 16 Total: 64</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on February 5, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form</p> | | | |

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| | <p>of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to ensure the attending physician was notified of the unavailability of a physician-ordered medication in which the resident did not receive the medication for 11 days for 1 of 4 residents reviewed for medication administration in a sample of 5.. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's clinical record was reviewed on 1-27-16 at 10:25 a.m. Her diagnoses included, but were not limited to, chronic hepatitis, diabetes and hypertension. It indicated the admission physician orders included an order for Biotin, an over-the-counter B-vitamin, to administer 1,000 micrograms orally each</p> | F 0157 | <p>F 157 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #E is receiving medications as ordered.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all resident's medications to ensure they are available. If a medication is noted to not be available, the attending physician will be notified. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Physician Notification</p> <p>How the corrective</p> | 02/27/2016 |

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| | <p>day. The electronic medical administration record (EMAR) indicated the medication was listed as "Not Administered: Drug/Item unavailable" for 1-14-16 through 1-24-16. On 1-24-16, a notation in the EMAR indicated the facility's pharmacy had been contacted regarding the medication. The EMAR indicated the medication was administered, beginning on 1-25-16. Review of the EMAR and nursing progress notes did not reflect any documentation of any prior notification to the pharmacy regarding this medication. Review of the EMAR and nursing progress notes did not reflect any documentation of notification to the physician regarding the medication not being available for administration, nor checking the EDK for medication availability, nor checking with the back up pharmacy for medication availability .</p> <p>In interview with the Corporate Nurse Consultant on 1-27-16 at 4:35 p.m., she indicated if a medication is unavailable to administer, staff are to first check the facility's EDK (emergency drug kit). If it is not available in the EDK, then the facility's back up pharmacy is to be contacted for the medication. If the back up pharmacy would not have the medication, then the staff are to notify the attending physician of the situation, with</p> | | <p>measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted on 5 residents by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review of resident's medications to ensure they are available. If a medication is noted to not be available, the attending physician will be notified. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| F 0225 SS=D Bldg. 00 | <p>the physician being able to order to hold the medication or provide a change to the medication order.</p> <p>In interview with the Corporate Nurse Consultant on 1-28-16 at 3:30 p.m., she indicated she could not locate a written policy or procedure related on actions for staff to take for unavailable medications.</p> <p>This Federal tag relates to Complaint IN00190826.</p> <p>3.1-25(b)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law</p> | | | |

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| | <p>through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of misappropriation of property was reported to the Indiana State Department of Health and other agencies for 1 of 5 residents reviewed for abuse in a sample of 5. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's clinical record was reviewed on 1-27-16 at 9:25 a.m. It indicated her diagnoses included, but were not limited to, chronic back pain, depression and hypertension. Her Minimum Data Set assessments on 1-7-15, 4-1-15 and 7-31-15, indicated she was cognitively intact.</p> | F 0225 | <p>F 225 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #D has been discharged. An investigation into the allegation of misappropriation was complete and the alleged incident was investigated by the surveyor during the 1/28/16 complaint survey.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All reported allegations of misappropriation of property since the 1/28/16 complaint survey has been reported to the Indiana State Department of Health.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient</p> | 02/27/2016 |

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| | <p>On 1-26-16 at 4:05 p.m., the Executive Director provided a copy of a "Resident Concern Form," dated 10-30-15 at 6:45 p.m. This form indicated Resident #D was "concerned," and "upset," regarding money she had loaned to an employee and the money had not been repaid. The form indicated the Executive Director had been notified by email "to speak to her before she leaves [transfers to another facility, scheduled for the following day.] The form indicated on 11-2-15, the Executive Director had met with the resident at another facility, where she had transferred to on 10-31-15, to discuss the situation. It indicated the "Resident explained that she had loaned some money to one of the [facility's] employees and he was supposed to pay her back before she discharged. He did not." The form continued, "Staff member interviewed, denies it happened. Resident cannot recall when the loans were given to [facility's] staff member. Resident also assured ED [Executive Director] many times that she did not want the money back or anything to come of the investigation, only to notify me should something like this happen to any other resident."</p> <p>In an interview with the Executive Director on 1-27-16 at 3:40 p.m., he indicated he did not report the allegation,</p> | | <p>practice does not recur: The Executive Director (ED) or designee will educate the campus Leadership Team on the campus guidelines for 1). State Reportable Events 2). Abuse and Neglect How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the ED or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: The Indiana State Department of Health-Long Term Care Division is notified of all alleged violations of misappropriation of property. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>"Just a decision not to file," due to the resident "did not want a resolution to the financial end of this." He indicated he had discussed this event with his superiors.</p> <p>On 1-28-16 at 2:30 p.m., the Director of Health Services provided a copy of a policy entitled, "Abuse and Neglect Procedural Guidelines." This policy had a revision date of 9-16-11, and was indicated to be the current policy utilized by the facility. This policy indicated, "[Name of Corporation] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and neglect...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures.</p> <p>Definitions...Misappropriation of Property-includes, but is not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds...The Executive Director is accountable for investigating and reporting...The executive Director is responsible for: Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local</p> | | | |

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| F 0226 SS=D Bldg. 00 | <p>law enforcement agencies, as indicated...Any staff member, resident, visitor, or responsible party may report known or suspected abuse, neglect or misappropriation to local or state agencies. Immediately and not more than 24 hours complete an initial report to applicable state agencies...A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days."</p> <p>This Federal tag relates to Complaint IN00191862.</p> <p>3.1-28(a) 3.1-28(c) 3.1-28(e)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to implement their policies and procedures related to abuse</p> | F 0226 | F 226 Corrective actions accomplished for those residents found to be affected by the alleged deficient | 02/27/2016 |

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| | <p>in that an allegation of misappropriation of property was not reported to the Indiana State Department of Health and other agencies 1 of 5 residents reviewed for abuse in a sample of 5. (Resident #D)</p> <p>Findings include:</p> <p>Resident #D's clinical record was reviewed on 1-27-16 at 9:25 a.m. It indicated her diagnoses included, but were not limited to, chronic back pain, depression and hypertension. Her Minimum Data Set assessments on 1-7-15, 4-1-15 and 7-31-15, indicated she was cognitively intact.</p> <p>On 1-26-16 at 4:05 p.m., the Executive Director provided a copy of a "Resident Concern Form," dated 10-30-15 at 6:45 p.m. This form indicated Resident #D was "concerned," and "upset," regarding money she had loaned to an employee and the money had not been repaid. The form indicated the Executive Director had been notified by email "to speak to her before she leaves [transfers to another facility, scheduled for the following day.] The form indicated on 11-2-15, the Executive Director had met with the resident at another facility, where she had transferred to on 10-31-15, to discuss the situation. It indicated the "Resident explained that she had loaned some</p> | | <p>practice: Resident #D has been discharged. An investigation into the allegation of misappropriation was complete and the alleged incident was investigated by the surveyor during the 1/28/16 complaint survey.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All reported allegations of misappropriation of property since the 1/28/16 complaint survey has been reported to the Indiana State Department of Health.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The Executive Director (ED) or designee will educate the campus Leadership Team on the campus guidelines for 1). State Reportable Events 2). Abuse and Neglect How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the ED or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: The Indiana State Department of Health-Long Term Care Division is notified of all alleged violations of misappropriation of property. The results of the audit observations will be reported,</p> | |

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| | <p>money to one of the [facility's] employees and he was supposed to pay her back before she discharged. He did not." The form continued, "Staff member interviewed, denies it happened. Resident cannot recall when the loans were given to [facility's] staff member. Resident also assured ED [Executive Director] many times that she did not want the money back or anything to come of the investigation, only to notify me should something like this happen to any other resident."</p> <p>In an interview with the Executive Director on 1-27-16 at 3:40 p.m., he indicated he did not report the allegation, "Just a decision not to file," due to the resident "did not want a resolution to the financial end of this." He indicated he had discussed this event with his superiors.</p> <p>On 1-28-16 at 2:30 p.m., the Director of Health Services provided a copy of a policy entitled, "Abuse and Neglect Procedural Guidelines." This policy had a revision date of 9-16-11, and was indicated to be the current policy utilized by the facility. This policy indicated, "[Name of Corporation] has developed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident abuse and</p> | | <p>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>neglect...The Executive Director and Director of Health Services are responsible for the implementation and ongoing monitoring of abuse standards and procedures.</p> <p>Definitions...Misappropriation of Property-includes, but is not limited to, the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds...The Executive Director is accountable for investigating and reporting...The executive Director is responsible for: Notification to the State Department of Health (per State guidelines) and other agencies, which include the Ombudsman, Adult Protective Services and/or local law enforcement agencies, as indicated...Any staff member, resident, visitor, or responsible party may report known or suspected abuse, neglect or misappropriation to local or state agencies. Immediately and not more than 24 hours complete an initial report to applicable state agencies...A written report of the investigation outcome, including resident response and/or condition, final conclusion and actions taken to prevent reoccurrence, will be submitted to the applicable State Agencies within five days."</p> <p>This Federal tag relates to Complaint IN00191862.</p> | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 01/28/2016 |
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| NAME OF PROVIDER OR SUPPLIER CLEARVISTA LAKE HEALTH CAMPUS | STREET ADDRESS, CITY, STATE, ZIP CODE 8405 CLEARVISTA PLACE INDIANAPOLIS, IN 46256 |
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| F 0387 SS=D Bldg. 00 | <p>3.1-28(a) 3.1-28(c) 3.1-28(e)</p> <p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on interview and record review, the facility failed to ensure 1 of 5 residents reviewed for frequency of physician visits in a sample of 5 had routine physician visits conducted in collaboration with the nurse practitioner. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 1-25-16 at 11:45 a.m. His diagnoses included, but were not limited to Parkinson's disease, history of peritonitis, vascular dementia, nephritis, and hypertension. Review of the visits conducted by the attending physician and the collaborating nurse practitioner</p> | F 0387 | <p>F 387 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all resident's medical records to ensure a routine physician visit is conducted in collaboration with the nurse practitioner. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing Leadership Team on the</p> | 02/27/2016 |

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| | <p>indicated the attending physician conducted the initial history and physical visit on 8-12-15. Subsequent visits by the nurse practitioner were conducted on 10-16-15, 10-30-15, 11-17-15, 12-17-15 and 1-15-16.</p> <p>In an interview on 1-28-16 at 11:30 a.m., with the nurse practitioner, she indicated she began seeing residents at the facility in October, 2015. She indicated the current Medical Director/attending physician began at the same time. She indicated not long after they began seeing residents at the facility, the Medical Director had one of his partners in his other practice become very ill, causing him to have more responsibilities in that practice. She shared that the Medical Director is actively working on trying to be available on site more frequently.</p> <p>On 1-26-16 at 4:25 p.m., an interview was conducted with the Corporate Nurse Consultant and the Executive Director. The Executive Director indicated the medical records staff position has been vacant "for a while." The Consultant indicated the medical records staff are responsible for tracking of physician visits for each resident. She indicated, due to the vacancy, the physician visits have not been tracked.</p> | | <p>following guideline: Physician Services How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: a routine physician visit is conducted in collaboration with the nurse practitioner. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>On 1-28-16 at 2:52 p.m., the Director of Health Services provided a copy of a policy entitled, "Guidelines for Physician Services." This policy did not have a date of development, but was indicated to be the current policy in use by the facility. This policy indicated, "The resident's attending physician shall participate in the resident's assessment and care planning, monitor changes in resident's medical status, and provide consultation or treatment as required by resident's condition, regulations and/or when consulted/called by the campus. The resident's attending physician is responsible for prescribing new therapy, ordering a transfer to the hospital, conducted required visits, delegating and supervising follow-up visits from nurse practitioners or physician assistants, etc., to ensure that the resident receives quality care and medical treatments...Physician visits, frequency of visits, emergency care of residents, etc., are provided in accordance with current OBRA regulations and campus policy."</p> <p>This Federal tag relates to Complaint IN00190826.</p> <p>3.1-22(d)(1) 3.1-22(d)(2) 3.1-22(d)(3) 3.1-22(d)(4)</p> | | | |

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| F 0411 SS=D Bldg. 00 | <p>3.1-22(f)(1) 3.1-22(f)(2)</p> <p>483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care.</p> <p>A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on interview and record review, the facility failed to make arrangements for further dental services for 1 of 4 residents reviewed for dental services in a sample of 5 in which the contracted dental provider referred the resident for additional care and services. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 1-25-16 at 11:45 a.m. His diagnoses included, but were not limited</p> | F 0411 | <p>F 411 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #B has been discharged. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents' medical records will be reviewed to identify any referrals for dental services made. If a referral is identified, Nursing and / or Social Service will then make arrangements for the appointment. Measures</p> | 02/27/2016 |

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| | <p>to Parkinson's disease, history of peritonitis, vascular dementia, nephritis, and hypertension.</p> <p>The facility's contracted dental provider had conducted a visit with Resident #B on 8-31-15. Documentation from that visit indicated the resident complained of pain to the upper left portion of his mouth with all tissues appearing to be within normal range. The contracted dental provider had referred the resident for additional care and services of dental xrays and dental cleaning with full mouth debridement to rule out dental decay below the gumline or cracks around or under the resident's current dental fillings.</p> <p>In review of Resident #B's clinical record, a lack of documentation was denoted regarding acknowledgement of the referral recommendation by the facility or any follow up to schedule a dental appointment.</p> <p>In interview with the Corporate Nurse Consultant on 1-26-16 at 10:05 a.m., she indicated she was unable to locate any information in Resident #B's clinical record that indicated anything had been done in reference to the dental referral from 8-31-15. She indicated, "Normally, the nurse on duty should have reviewed</p> | | <p>put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses, Nursing Leadership Team and Social Service on the following: Dental progress note review after evaluation to identify any referrals for dental services made. In addition, then follow up to make arrangements for the appointment. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audit will be conducted by the DHS or designee 1 time per month (after each monthly dentist visit) times 6 months to ensure compliance: Dental progress note review after evaluation to identify any referrals for dental services made. In addition, then follow up to make arrangements for the appointment. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| F 0425 SS=D Bldg. 00 | <p>the referral and spoken with the resident or the family in regards to which dentist they preferred and made arrangements from there."</p> <p>In interview with the Corporate Nurse Consultant on 1-28-16 at 3:30 p.m., she indicated she could not locate a written policy or procedure related to referrals.</p> <p>This Federal tag relates to Complaint IN00190826.</p> <p>3.1-24(a)(1) 3.1-24(b)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> | | | |

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| | <p>Based on interview and record review, the facility failed to ensure a physician-ordered medication was provided as ordered for 1 of 4 residents reviewed for medication administration in a sample of 5, in that the medication was unavailable for administration for 11 days. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's clinical record was reviewed on 1-27-16 at 10:25 a.m. Her diagnoses included, but were not limited to, chronic hepatitis, diabetes and hypertension. It indicated the admission physician orders included an order for Biotin, an over-the-counter B-vitamin, to administer 1,000 micrograms orally each day. The medication order did not specify the purpose of its use. The electronic medical administration record (EMAR) indicated the medication was listed as "Not Administered: Drug/Item unavailable" for 1-14-16 through 1-24-16. On 1-24-16, a notation in the EMAR indicated the facility's pharmacy had been contacted regarding the medication. The EMAR indicated the medication was administered, beginning on 1-25-16. Review of the EMAR and nursing progress notes did not reflect any documentation of any prior notification to the pharmacy regarding this</p> | F 0425 | <p>F 425 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #E is receiving all medications as ordered by the physician.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all resident's medications to ensure they are being administered as ordered by the physician. MD is to be notified if medication is not available to administer.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: Medication Administration How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review all resident's medications to ensure they are being administered as ordered by the physician. MD is to be notified if medication is not available to administer. The results of</p> | 02/27/2016 | | | |

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| | <p>medication. Review of the EMAR and nursing progress notes did not reflect any documentation of notification to the physician regarding the medication not being available for administration, nor checking the EDK for medication availability, nor checking with the back up pharmacy for medication availability.</p> <p>In interview with the Corporate Nurse Consultant on 1-27-16 at 4:35 p.m., she indicated if a medication is unavailable to administer, staff are to first check the facility's EDK (emergency drug kit). If it is not available in the EDK, then the facility's back up pharmacy is to be contacted for the medication. If the back up pharmacy would not have the medication, then the staff are to notify the attending physician of the situation, with the physician being able to order to hold the medication or provide a change to the medication order.</p> <p>In interview with the Corporate Nurse Consultant on 1-28-16 at 3:30 p.m., she indicated she could not locate a written policy or procedure related on actions for staff to take for unavailable medications.</p> <p>This Federal tag relates to Complaint IN00190826.</p> <p>3.1-25(b)</p> | | <p>the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| F 0514 SS=D Bldg. 00 | <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</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 interview and record review, the facility failed to ensure resident records are complete, readily accessible and organized for 1 of 4 residents reviewed for resident assessments in a sample of 5. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 1-26-16 at 10:00 a.m. Her diagnoses included, Alzheimer's disease, history of urinary tract infections and clostridium difficile.</p> <p>During the entrance conference with the Executive Director on 1-25-16, he indicated the facility had begun utilizing an electronic medical record (EMR) in October, 2015 and the majority of all</p> | F 0514 | <p>F 514 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #C medical record is complete, readily accessible and organized.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all resident's medical record to ensure it is complete, readily accessible and organized.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses and Nursing Leadership Team on the following: Medical Records</p> | 02/27/2016 |

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| | <p>resident records were available on the EMR.</p> <p>During the process of the record review for Resident #C, nurse practitioner orders were noted for frequent laboratory testing. When attempting to view the laboratory reports under the "Laboratory," tab, only a small percentage of the laboratory reports were found to have been scanned into the EMR. When this was brought to the attention of the Executive Director and the Corporate Nurse Consultant on 1-26-16 at the daily Exit Conference at 4:25 p.m., the Executive Director indicated the Medical Records staff position had been vacant for some time. The Consultant indicated "a lot" of items/documents for resident charts were in need of being scanned into the EMR system and were "stacks" and/or "piles" in the medical records office. She indicated, "a team from corporate" was being sent into the facility that same evening to begin scanning resident records into the EMR system.</p> <p>On 1-28-16 at 2:30 p.m., the Director of Health Services provided a copy of a policy entitled, "Guidelines for Medical Records Clinical Documentation." This policy had a development date of 9-25-14, and was identified as the policy</p> | | <p>Clinical Documentation How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review of the resident's medical record to ensure it is complete, readily accessible and organized. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p> | |

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| | <p>currently in effect for the facility. This policy indicated, "The campus shall maintain a complete, ongoing, and organized resident record on each resident from the time of admission until termination of the resident's stay at the campus...The legal medical record includes individually identifiable data, in any medium, collected and directly used in documenting healthcare and health status. This includes the open record, the thinned record, and the closed medical record...A complete, timely, and accurate resident record is created and maintained for each resident..."</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3) 3.1-50(a)(4)</p> | | | |