

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/03/2013
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NAME OF PROVIDER OR SUPPLIER LYND HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2410 E MCGALLIARD RD MUNCIE, IN 47303
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R000000	<p>This visit was for a State Licensure Survey.</p> <p>Survey dates: July 2 & 3, 2013</p> <p>Facility number: 004428 Provider number: 004428 AIM number: N/A</p> <p>Survey team: Karen Lewis, RN TC Ginger McNamee, RN Tina Smith-Staats, RN</p> <p>Census bed type: Residential : 43 Total: 43</p> <p>Census payor type: Other: 43</p> <p>Sample: 9</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Debora Barth, RN.</p>	R000000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of 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 any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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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R000043	<p>410 IAC 16.2-5-1.2(q)(1-2) Residents' Rights - Noncompliance (q) Residents have the right to appropriate housing assignments as follows: (1) When both husband and wife are residents in the facility, they have the right to live as a family in a suitable room or quarters and may occupy a double bed unless contraindicated for medical reasons by the attending physician. (2) Written facility policy and procedures shall address the circumstances in which persons of the opposite sex, other than husband and wife, will be allowed to occupy a bedroom, if such an arrangement is agreeable to the residents or the residents' legal representatives.</p> <p>Based on record review and interview, the facility failed to ensure the physician was notified when blood sugars were greater than the highest parameter set for sliding scale insulin coverage for 1 of 1 residents reviewed with sliding scale insulin coverage. (Resident #27)</p> <p>Findings include:</p> <p>Resident #27's clinical record was reviewed on 7/2/13 at 10:55 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, dementia and prior stroke.</p> <p>The resident had an order for her blood sugar to be checked three times a day and sliding scale Humalog insulin coverage was to be given. This order was initiated</p>	R000043	<p>Although we agree that the practices were deficient and they are being/were fixed, we believe that the tag number is inaccurate. What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>The resident's face sheet was updated to reflect the correct physician of record as to notification of abnormal blood sugar per parameters established by the prescriber. The MAR was also updated to include the physician to be contacted when blood sugars are outside acceptable parameters established by the physician. Staff were re-educated as to the policy and procedure as pertaining to blood sugar monitoring, physician notification per our change of condition policy and procedure as</p>	08/15/2013			

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	<p>on 2/19/13 and remained on the current physician's orders signed and dated on 6/14/13. The Nurse Practitioner wrote an order on 5/9/13 to be called for glucose levels greater than 400 mg/dl (milligrams/deciliter).</p> <p>Review of the resident's face sheet indicated the resident was seen by [name of physician] an endocrinologist for her diabetes.</p> <p>Review of the resident's blood sugars indicated the resident had a blood sugar of 488 mg/dl at 5:00 p.m. on 5/29/13. The resident's record lacked an indication of the Nurse Practitioner, the doctor, or the resident's endocrinologist being notified.</p> <p>During an interview with the Director of Nursing on 7/2/13 at 12:42 p.m., she indicated there was a note on the communication sheet the doctor had been faxed on 5/29/13. She indicated the doctor had returned the fax on 5/31/13 and indicated he was no longer this resident's doctor.</p> <p>During an interview with the resident's daughter on 7/3/13 at 8:30 a.m., she indicated she had informed the facility when she changed the resident's doctor. She indicated the endocrinologist was the doctor to be notified regarding her</p>		<p>well as obtaining physician orders.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>No other residents were found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>The Wellness Director will perform a random audit of resident face sheets to ensure they are current and accurate. The Wellness Director will conduct a random review of service notes to ensure appropriate follow-up has occurred and abnormal blood sugars are communicated to the appropriate physician for appropriate intervention.</p> <p>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?</p> <p>One member of the Regional team will conduct a random review resident service notes and resident face sheets once a month for 3 months and then upon quarterly visits thereafter.</p>				

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	<p>mother's blood sugars. She indicated he had been taking care of her mother's diabetes for 15 years.</p> <p>During an interview with LPN #1 on 7/3/13 at 9:45 a.m., he indicated the endocrinologist was to be notified for any high blood sugar results or concerns related to the residents diabetes. Review of the current policy, dated 1/2013, titled "VIII. PHYSICIAN'S ORDERS," provided by the Regional Director of Operations on 7/3/13 at 9:32 a.m., included, but was not limited to, the following:</p> <p>"...PHYSICIAN FAX TRANSMISSION-PHONE ORDER The Fax Transmission/Phone Order form may be used to inform a resident's physician of NON-EMERGENCY changes of condition, to request a new medication, to request a change in medication, to notify a resident's physician of a non-injury occurrence, or to report routine information to a resident's physician....</p> <p>...If no response is received from a physician for acute conditions (e.g. diarrhea, fever, sore throat, flu-like symptoms, productive cough, rashes, minor wounds, adverse reaction to medications, unrelieved pain, ineffective</p>		<p>By what date will the systemic changes be completed?</p> <p>08/15/2013</p>				

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	<p>medication, etc.) and it is nearing the end of the business day, a call should be placed to the physician for follow-up....</p> <p>...If the fax is sent simply to notify the physician of a non-acute occurrence (such as a non-injury fall, a behavioral episode, weekly vital signs, routine blood sugars, etc.), rather than to request intervention, the original copy should be reviewed by the nurse then filed in the resident's service binder under the tab labeled "Physician Services". However, if the physician returns the fax, with or without orders, place this copy in the resident's service binder and remove the original document that was faxed...."</p>						

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R000052	<p>410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview, the facility failed to ensure an investigation was completed following an unwitnessed fall for 1 of 1 unwitnessed falls reviewed to ensure abuse did not occur. (Resident #5)</p> <p>Findings include:</p> <p>The clinical record for Resident #5 was reviewed on 7/3/13 at 10: 34 a.m.</p> <p>Diagnoses for Resident #5 included, but were not limited to dementia, congestive heart failure, and osteoarthritis.</p> <p>Review of the fall investigation for the fall on 6/30/13 at 3:30 p.m., provided by the Regional Director of Operations, on 7/3/13 at 10:34 a.m., lacked any abuse investigation information.</p> <p>During an interview with the Director of Nursing (DoN) on 7/3/13 at 10:50 a.m., she indicated a staff member had found the resident on the floor in her apartment while doing rounds. The staff member</p>	R000052	<p>We respectfully disagree with the above referenced citation and request re-consideration of this citation based on the attached information by way of paper review.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>We respectfully disagree with the above referenced citation and request re-consideration of this citation based on the attached information by way of paper review.</p> <p>No residents were found to be affected. The state reportable incident occurred on 6/30/2013. The survey was concluded on 7/3/2013. At the time of the survey, the residence was still within the required 5 day window as to completion of the investigation. Statements were gathered and documented as part of the community's internal investigation prior to expiration of</p>	08/15/2013			

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	<p>notified the nurse on duty. The DoN further indicated the resident was able to answer questions in short sentences at the time of the fall. The DoN indicated she asked the resident what had happened when she fell. The DoN indicated the resident responded she did not know what had happened when she fell. The DoN indicated the resident "usually" kept the door to her apartment propped open. The DoN indicated the resident was not able to answer questions now due to decline in condition.</p> <p>During an interview with the DoN on 7/3/13 at 1:57 p.m., she indicated visitors in the facility had heard noises in the resident's apartment and notified a staff member.</p> <p>During an interview with Dietary Aide #3 on 7/3/13 at 2:14 p.m., she indicated a male visitor had came to the kitchen to inform the staff that a resident had fallen in her apartment. Dietary Aide #3 informed the Dietary Manager and then went to the resident's apartment. Two males were standing in the resident's apartment when Dietary Aide #3 entered the apartment and found the resident on the floor. Dietary aide #3 indicated the resident was not complaining of any pain and wanted to get up off of the floor. Dietary aide #3 instructed the resident to</p>		<p>the state allowed investigation time frame.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>No other residents were affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>The house management team was re-educated as to the abuse and neglect policy and procedure regarding timely incident reporting and investigation of incident/accidents of allegations pertaining to abuse/neglect.</p> <p>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?</p> <p>The regional team will audit records of incident/accident reports upon quarterly visits to ensure continued compliance as to the above referenced regulation.</p> <p>By what date will the systemic</p>				

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	<p>remain still until she could return with the nurse. The Dietary Manager remained with the resident while Dietary Aide #3 went to notify the nurse.</p> <p>Review of the current policy, dated 2011, titled "A. SUSPECTED ABUSE/NEGLECT/EXPLOITATION," provided by the Regional Director of Operations on 7/3/13 at 9:50 a.m., included, but was not limited to, the following:</p> <p>"...4. If abuse, neglect, or exploitation of a resident is suspected, act immediately to protect the resident from additional harm....</p> <p>...7. Initiate an investigation...."</p>		<p>changes be completed?</p> <p>8/15/2013</p>				

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R000273	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff followed hand washing protocols, prevented cross contamination while preparing food, thawed meat in a safe manner, prevented the storage of soiled items with clean items, and ensured the floor was clean for 2 of 2 observations. This deficient practice had the potential to effect 43 of 43 residents receiving meals in the facility.</p> <p>Findings include:</p> <p>The kitchen was observed on 7/2/13 from 8:53 a.m. to 9:20 a.m., with the Dietary Manager. The Dietary Manager washed her hands and turned off the faucet with her bare wet hands and proceeded to fix two plates of food to be served to residents.</p> <p>The food came from a steamer pan sitting on the counter. The pan contained scrambled eggs, bacon, and toast. The pan was shiny steel on the inside bottom and half way up the side of the pan and had a dark black coating on the rest of the</p>	R000273	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>No residents were found to be affected. The Dietary Manger is no longer employed at the community. A new Dietary Manager will be hired and will receive training per the Assisted Living Concept's Silver Platter Initiative, including but not limited to proper food handling and sanitation, proper hand washing, and frozen food thawing guidelines. Staff was re-educated as to proper hand washing guidelines per 410 IAC 7-24. Staff was re-educated as to company policy on cell phone usage while on the clock.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>No other residents were affected.</p> <p>What measures will be put into</p>	08/15/2013			

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	<p>pan inside and out. She indicated she did not know if the pan was originally all shiny and the black was burned on debris or if the pan was originally coated and part of the coating had worn away.</p> <p>There was an uncovered fryer pan filled with liquid oil stored in the bottom cabinet to the right of the two basin sink along with a soiled base unit to a blender.</p> <p>There were large black areas observed on the textured tan colored floor throughout the kitchen. The floor had several spots of different colored dried substances on it.</p> <p>The Dietary Manager was observed washing her hands at 9:15 a.m., she turned the faucet off with her bare wet hands.</p> <p>An observation of the kitchen was made on 7/2/13 from 11:25 a.m. to 12:20 p.m., with the Dietary Manager present. The right hand basin of the prep sink contained two plastic bags of frozen chicken breasts. The Dietary Manager indicated she was "just letting them defrost." She indicated they were for the evening meal. They were not being thawed under running water. On the right hand counter next to the prep sink was a tray containing two five pound tubes of partially thawed ground beef. The</p>		<p>place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>The Residence Director and/or Designee will monitor kitchen for cleanliness weekly, utilizing the developed and implemented kitchen sanitation checklist. The Residence and/or Designee will monitor staff hand washing weekly for four weeks and randomly for three months after that.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The regional team will review the kitchen sanitation logs and staff hand washing practices upon their quarterly visits.</p> <p>By what date will the systemic changes be completed?</p> <p>08/15/2013</p>				

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	<p>Dietary Manager indicated the meat was to be used to make sloppy joes and beef barley soup for the evening meal alternatives.</p> <p>CNA #2 entered the kitchen at 11:32 a.m., washed her hands and turned the faucets off with her bare wet hands and proceeded to make coffee.</p> <p>Dietary Aide #3 washed her hands at 11:33 a.m., she turned the faucet off with her bare wet hands.</p> <p>During an interview with the Dietary Manager at 11:35 a.m., she indicated the large black areas observed on the tan colored floor were just dirty areas. She indicated she had a two basin prep sink for cleaning and prepping food, a one basin sink for preparing drinks and a three basin sink for cleaning dishes.</p> <p>At 11:50 a.m., the Dietary Manager was observed making cake icing. She obtained water to mix into the icing mix from the three basin sink.</p> <p>CNA #2 was observed at the one basin sink mixing beverages for lunch at 11:52 a.m. She was observed removing her phone from her pocket, texting, replacing the phone back in her pocket and continuing to mix drinks. She then went</p>			

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	<p>to an utensil drawer and sorted through it for a pair of scissors. She used the scissors to open two packages of powdered drink mix. She placed the powder mix into pitchers and made a second pot of coffee. At 11:56 a.m., she went to the utensil drawer and retrieved a rubber spatula to stir the powder drink mixes. No hand washing was observed after CNA #2 was observed texting.</p> <p>At 12:15 p.m., the Dietary Manager was observed reaching inside the waistband of her uniform pants and pulling them up. Without washing her hands, she put away the temperature logs, returned three clean plates to the stack of clean plates and dished up applesauce.</p> <p>CNA #2 was observed washing her hands at 12:17 p.m. She turned the water off with her bare wet hands.</p> <p>The Dietary Manager was observed at 12:18 p.m., she placed a cookie sheet on the counter and donned gloves. She placed rolls on the cookie sheet. She removed her gloves and placed the rolls in the oven. No hand washing was observed.</p> <p>During an interview with the Regional Director of Operations on 7/3/13 at 3:01 p.m., she indicated the facility did not</p>						

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	<p>have specific hand washing policies for dietary. She indicated the dietary department followed "Retail Food Establishment Sanitation Requirements" for all their procedures in the kitchen.</p> <p>During an interview with the Regional Director of Operations on 7/2/13 at 5:00 p.m., she had observed the meat in the sink and on the counter. She indicated it was not being thawed properly. She indicated staff were to only use their cell phones during their breaks and were not to have their phones on their persons.</p>						