

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155757	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/19/2015
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NAME OF PROVIDER OR SUPPLIER ROSEGATE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 7510 ROSEGATE DR INDIANAPOLIS, IN 46237
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: May 13, 14, 15, 18, 19, and 20, 2015</p> <p>Facility number: 011149 Provider number: 155757 AIM number: 200829340</p> <p>Census bed type: SNF: 19 SNF/NF: 119 Total: 138</p> <p>Census payor source: Medicare: 32 Medicaid: 74 Other: 32 Total: 138</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Rosegate Village respectfully requests desk review in lieu of an onsite visit	
F 0282 SS=E Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's</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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	<p>written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure plans of care were followed for notifying the physician regarding blood pressure results (Resident #6), obtaining a special cushion for a wheelchair to help prevent falls (Resident #227), applying a splint for leg weakness (Resident #38), applying compression stockings (Resident #27), and obtaining a laboratory blood test (Resident #152).</p> <p>Findings include:</p> <p>1. The clinical record of Resident #6 was reviewed on 5/18/15 at 3:48 p.m. Diagnoses for the resident included, but were not limited to high blood pressure.</p> <p>A current physician's order with an original date of 3/28/15, indicated, "Please check blood pressure every am and every evening. Call SBP [systolic blood pressure] <100 >150, DBP [diastolic blood pressure] <60 >90." Systolic blood pressure is the pressure exerted on the walls of the blood vessels when the heart contracts (beats). Diastolic blood pressure is the pressure exerted on the walls of the blood vessels when the heart is at rest.</p>	F 0282	<p>F- 282-Services by Qualified Persons/Per Care Plan What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #6 no longer resides in the facility. ·Resident #227 was found to be in his roommate's wheelchair and was immediately relocated to his wheelchair that had his special wheelchair cushion. Resident #227 wheelchair was immediately labeled with his name in an inconspicuous place for easy identification. ·Resident #38 doctor and family agreed to discontinue the order for applying a leg splint due to none compliance. ·Resident #27 immediately applied compression stockings per plan of care. ·Resident #152 physician was notified, order obtained for valporic acid level to be obtained on 5/20/15, results indicated valporic acid was in therapeutic range, valporic acid level was ordered to be drawn Q 6 months. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents receiving medication with orders requiring 	06/12/2015	

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	<p>A current physician's order with an original date of 3/26/15, indicated Resident #6 was to receive atenolol, 50 mg (milligrams) every day. Atenolol is given to treat high blood pressure.</p> <p>A current physician's order with an original date of 5/6/15, indicated Resident #6 was to receive ramipril 5 mg. twice a day. Ramipril is a medication for the treatment of high blood pressure.</p> <p>A current care plan for Resident #6, with an original date of 4/3/15, indicated a problem of high blood pressure. The goal was, "Resident will maintain adequate tissue perfusion as evidenced by blood pressure within normal limits for resident..." Interventions included, "Administer meds [medications] as ordered," and "Observe for...variations in B/P [blood pressure] Notify MD (medical doctor)."</p> <p>Documentation Flowsheets for April and May, 2015, indicated the following:</p> <p>4/2 at 9:00 a.m.: blood pressure 160/91 4/10 at 5:00 p.m. blood pressure 108/58 4/19 at 9:00 a.m. blood pressure 199/66 5/9 at 9:00 a.m. blood pressure 112/54 5/14 at 9:00 a.m. blood pressure 120/56</p> <p>No indications were found in Resident</p>		<p>MD notification related to blood pressure monitoring, with assistive devices to prevent falls, requiring splints and/or compression stockings, and for residents who have MD ordered labs related to medications used for mood stabilization have potential to be affected by the alleged deficient practice.</p> <p>·All residents requiring MD notification related to blood pressure monitoring have been identified and a daily audit by the DNS and/or designee has been initiated to ensure MD notification per Physician order. MD was notified of any residents who were identified as having been effected by the alleged deficient practice.</p> <p>·All residents with assistive devices to prevent falls, requiring splints and/or compression stockings, and for residents who have MD ordered labs related to medications used for mood stabilization have been identified and a daily audit by the DNS and/or designee has been initiated to ensure interventions are in place plan of care.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·Nursing staff in-service on MD notification related to blood pressure monitoring, implementation of assistive</p>	

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	<p>#6's clinical record the physician was notified regarding the above blood pressures outside the call parameters.</p> <p>On 5/19/15 at 2:07 p.m., the Director of Nursing indicated she was unable to find any information the physician had been notified of the blood pressures outside call parameters, according to the resident's plan of care.</p> <p>2. The clinical record review for Resident #227, was completed on 5/18/15 at 9:40 a.m. Diagnoses included, but were not limited to, osteoporosis and peripheral vascular disease.</p> <p>A careplan for Resident #227, dated 4/15/15 and updated 4/27/15, indicated resident is at risk for falls. Interventions included, but were not limited to, "...wedge cushion on w/c [wheelchair]...."</p> <p>A review of the ASC (American Seniors Community) Fall Event dated 4/24/15, indicated Resident #227 slid from his wheelchair onto the floor. "...What intervention (s) was put into place to prevent another fall: replaced w/c [wheelchair] cushion with wedge cushion...."</p> <p>A review of the Interdisciplinary Team (IDT) progress noted dated 4/26/15, indicated, "...Immediate intervention was</p>		<p>devices per plan of care,application of splints and/or compression stockings per plan of care, followingMD orders related to lab monitoring of medications used for mood stabilization willbe completed by the Director of Nursing and/or designee by June 12, 2015.</p> <p>·All Residents requiring MD notificationrelated to blood pressure monitoring have been identified and a daily audit byDNS and/or designee has been initiated to ensure MD notification per Physicianorder.</p> <p>·All residents using assistive devices toprevent falls, requiring splints and/or compression stockings, and forresidents who have MD ordered labs related to moodstabilization have been identified and a daily audit by DNS or designee has beeninitiated to ensure interventions are in place per plan of care</p> <p>How the corrective action (s) will bemonitored to ensure the deficient practice will not recur, i.e., what qualityassurance program will be put into place?</p> <p>·Notification of Blood Pressure per MDOrder, Following Plan of Care, Assistive Devices Related to Falls, andFollowing MD Ordered Labs for Mood Stabilizer Medication CQI audit tools will be utilized by the Director of Nursingand/or designee to</p>				

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	<p>to replace current wheel chair cushion with a wedge cushion to allow resident to position self better in wheel chair, IDT feels the root cause of fall was related to the positioning of the cushion...."</p> <p>A review of the ASC IDT (Interdisciplinary Team) Adaptive Device Review dated 4/28/15, indicated Resident #227 used a wedge cushion to his wheelchair for positioning.</p> <p>During an observation on 5/18/15 at 11:09 a.m., Registered Physical Therapist (RPT) #8 assisted Resident #227 out of the wheelchair the resident was currently sitting in. RPT #8 indicated the wheelchair cushion currently in place was a regular wheelchair cushion.</p> <p>The current physicians order dated 4/24/15, reviewed on 5/19/15 at 2:39 p.m., indicated "...Order Description: Wedge cushion for positioning Frequency: Every Shift...."</p> <p>3. The clinical record review for Resident #152, was completed on 5/15/15 at 4:50 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbances.</p> <p>A review of the current physician orders on 5/15/15 at 4:50 p.m., indicated</p>		<p>monitor compliance. Audits will be completed weekly X 4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters.</p> <p>·Results of Audit tools will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action.</p> <p>·If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p>		

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	<p>Resident #152 was to receive Depakote Sprinkles 750 mg by mouth twice a day to treat dementia with behavior disturbances.</p> <p>A review of a lab order for Resident #152, dated 12/11/14, indicated a valporic acid level (anticonvulsant/Depakote blood level) was to be drawn on the 4th Friday of January, May, and September.</p> <p>A review of Resident 152's valporic acid level report dated 1/6/15, indicated no valporic acid level was drawn for January 2015.</p> <p>During an interview on 5/19/15 at 4:55 p.m., the Director of Nursing Services (DNS), indicated a valporic acid level for Resident #152 was not completed as ordered by physician. The DNS also indicated the valporic acid level to be drawn, per order, was not placed in the lab tracking book.</p> <p>Review of the "GUIDELINES FOR LAB TRACKING", provided by the DNS on 5/20/15 at 11:25 a.m., indicated "...Review MD [Medical Director] orders and place in tracking binder at time order reviewed...."</p> <p>4. The clinical record review of Resident</p>			

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	<p>#38, completed 5/15/15 at 5:02 p.m., indicated the resident had diagnoses including, but not limited to, congestive heart failure.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, completed 4/8/15, indicated the resident required extensive assistance of 2 or more staff members for bed mobility, transfers, toileting, and personal hygiene. The resident was assessed as having a BIMS (Brief Interview for Mental Status) of 3 out of 15, indicating severe cognitive impairment.</p> <p>The recapitulation of physical's orders dated 5/1/15 - 5/31/15, indicated the resident had an order dated 4/2/15, "Patient to wear knee braces during the day when up in wheelchair...for leg weakness..."</p> <p>The resident had a care plan dated 4/9/15, indicating the resident required a splint program. The interventions included bilateral knee splints while up in the wheelchair during the day.</p> <p>On 5/15/15 at 4:39 p.m., the Assistant Director of Nursing Services (ADNS) provided the resident profile for Resident #38 and indicated the profile was currently used by the Certified Nursing</p>				

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	<p>Assistants (CNAs) as an assignment sheet. The ADNS indicated the profile contained information regarding care to be provided to the resident. The profile indicated the resident should have bilateral knee braces in place when up in the wheelchair during the day.</p> <p>On 5/14/15 at 3:00 p.m., the resident was observed up in the wheelchair without knee braces in place.</p> <p>On 5/15/15 at 10:30 a.m., the resident was observed up in the wheelchair without braces in place.</p> <p>On 5/18/15 at 11:34 a.m., the resident was observed sitting up in a wheelchair in the resident's room. The resident did not have knee braces in place.</p> <p>On 5/19/15 at 9:15 a.m., the resident was observed sitting in the dining room eating breakfast. The resident did not have knee braces in place.</p> <p>During an interview with Licensed Practical Nurse (LPN) #6 on 5/19/15 at 2:53 p.m., LPN #6 indicated the knee braces were not on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) and she would have to ask about the knee braces.</p>			

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	<p>During an interview with the Director of Nursing Services (DNS) on 5/20/15 at 9:45 a.m., the DNS indicated the order for the knee braces was placed in the physician's orders in the general section of the orders and was not placed onto the MAR or TAR. The DNS indicated the facility did not have documentation of the knee braces being applied as ordered.</p> <p>5. The clinical record review of Resident #27, completed on 5/15/15 at 4:19 p.m., indicated the resident had diagnoses including, but not limited to congestive heart failure.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, completed 4/1/15, indicated the resident required extensive assistance of 1 or 2 staff members for bed mobility, transfers, toileting, and personal hygiene. The resident was assessed as having a BIMS (Brief Interview for Mental Status) of 10 out of 15, indicating moderate cognitive impairment.</p> <p>The recapitulation of physical's orders dated 5/1/15 - 5/31/15, indicated the resident had an order dated 4/20/15, "Staff to apply compression socks on in the a.m. and off in the p.m...." Compression socks are used to improve circulation for residents having swelling</p>			

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	<p>in the legs.</p> <p>The resident had a current care plan with an origination date of 8/9/11, indicating the resident required assistance with Activities of Daily Living (ADLs) related to weakness and impaired mobility. The interventions included, but were not limited to, an approach 4/23/15, "Staff to donn [put on] compression socks in am [a.m.] doff off [remove] pm [p.m.]..."</p> <p>On 5/15/15 at 4:39 p.m., the Assistant Director of Nursing Services (ADNS) provided the resident profile for Resident #27 and indicated the profile was currently used by the Certified Nursing Assistants (CNAs) as an assignment sheet. The ADNS indicated the profile contained information regarding care to be provided to the resident. The profile indicated the staff should apply compression socks for the resident in the mornings and remove the compression socks in the evenings.</p> <p>On 5/15/15 at 10:30 a.m., the resident was observed up in the wheelchair with one plain black sock on the right foot and was holding a plain black sock. The resident's feet and legs were swollen and dry patches of skin were observed. The resident indicated assistance was needed to get the socks onto both feet.</p>			

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	<p>On 5/18/15 at 11:40 a.m., the resident was observed sitting up in a wheelchair in the resident's room. The resident did not have compression socks in place.</p> <p>On 5/18/15 at 3:30 p.m., the resident was observed sitting up in the wheelchair in the resident room. The resident had plain black socks in place with house slippers on the feet.</p> <p>On 5/19/15 at 9:45 a.m., the resident was observed sitting in the entry way of the resident's room. The resident did not have compression socks in place.</p> <p>On 5/19/15 at 2:00 p.m., the resident was observed sitting in the wheelchair next to the bed. The resident had plain black socks and house slippers on the feet.</p> <p>During an interview with Licensed Practical Nurse (LPN) #6 on 5/19/15 at 2:45 p.m., LPN #6 indicated the resident had an order for compression socks to be applied in the mornings and removed at night. LPN #6 indicated the Treatment Administration Record (TAR) had documentation of the compression socks being applied in the mornings and removed in the evenings.</p> <p>During an interview with the Director of</p>			

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F 0309 SS=D Bldg. 00	<p>Nursing Services (DNS) on 5/19/15 at 4:45 p.m., the DNS indicated the staff had informed her of the resident having documentation of the compression socks being applied and removed each day when in fact the resident did not have compression socks in place.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a splint for leg weakness was applied (Resident #38) and compression stockings were implemented (Resident #27) in accordance with the residents' assessment and plan of care.</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #38, completed 5/15/15 at 5:02 p.m., indicated the resident had diagnoses including, but not limited to, congestive heart failure.</p>	F 0309	<p>F- 309-Provide Care/Services for Highest Well Being What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #38 doctor and family agreed to discontinue the order for applying a splint due to non-compliance. ·Resident #27 immediately applied compression stockings per plan of care. <p>How will you identify other residents having the potential to be affected by the same deficient practice and</p>	06/12/2015

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	<p>A Significant Change Minimum Data Set (MDS) assessment, completed 4/8/15, indicated the resident required extensive assistance of 2 or more staff members for bed mobility, transfers, toileting, and personal hygiene. The resident was assessed as having a BIMS (Brief Interview for Mental Status) of 3 out of 15, indicating severe cognitive impairment.</p> <p>The recapitulation of physical's orders dated 5/1/15 - 5/31/15, indicated the resident had an order dated 4/2/15, "Patient to wear knee braces during the day when up in wheelchair...for leg weakness..."</p> <p>The resident had a care plan dated 4/9/15, indicating the resident required a splint program. The interventions included bilateral knee splints while up in the wheelchair during the day.</p> <p>On 5/15/15 at 4:39 p.m., the Assistant Director of Nursing Services (ADNS) provided the resident profile for Resident #38 and indicated the profile was currently used by the Certified Nursing Assistants (CNAs) as an assignment sheet. The ADNS indicated the profile contained information regarding care to be provided to the resident. The profile</p>		<p>what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents requiring application of splints and/or compression stockings have the potential to be affected by the alleged deficient practice. ·All residents requiring splints and/or compression stockings have been identified and a daily Audit by DNS and/or designee has been initiated to ensure interventions are in place in accordance with plan of care. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·The Director of Nursing Services and/or designee will ensure all orders for residents who require application of splints and/or compression stockings are added to the treatment administration record and the resident profile. ·An in-service will be completed by the Director of Nursing and/or designee on or before June 12, 2015, to nursing staff regarding application of splints and compression stockings per plan of care. ·All residents requiring splints and/or compression stockings have been identified and a daily Audit by DNS and/or designee has been initiated to ensure interventions are in place in accordance with plan of care. <p>How the corrective action</p>	

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	<p>indicated the resident should have bilateral knee braces in place when up in the wheelchair during the day.</p> <p>On 5/14/15 at 3:00 p.m., the resident was observed up in the wheelchair without knee braces in place.</p> <p>On 5/15/15 at 10:30 a.m., the resident was observed up in the wheelchair without braces in place.</p> <p>On 5/18/15 at 11:34 a.m., the resident was observed sitting up in a wheelchair in the resident's room. The resident did not have knee braces in place.</p> <p>On 5/19/15 at 9:15 a.m., the resident was observed sitting in the dining room eating breakfast. The resident did not have knee braces in place.</p> <p>During an interview with Licensed Practical Nurse (LPN) #6 on 5/19/15 at 2:53 p.m., LPN #6 indicated the knee braces were not on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) and she would have to ask about the knee braces.</p> <p>During an interview with the Director of Nursing Services (DNS) on 5/20/15 at 9:45 a.m., the DNS indicated the order</p>		<p>(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·The Following Plan of Care CQI audittool will be utilized by the Director of Nursing and/or Designee to monitorcompliance with application of splints and/or compression stockings weekly X 4weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. ·Results of these evaluation processeswill be presented to the CQI Committee monthly to review for compliance andfollow-up. Identified noncompliance may result in staff re-education and/ordisciplinary action. ·If threshold of 95% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. 	

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	<p>for the knee braces was placed in the physician's orders in the general section of the orders and was not placed onto the MAR or TAR. The DNS indicated the facility did not have documentation of the knee braces being applied as ordered.</p> <p>2. The clinical record review of Resident #27, completed on 5/15/15 at 4:19 p.m., indicated the resident had diagnoses including, but not limited to congestive heart failure.</p> <p>A Significant Change Minimum Data Set (MDS) assessment, completed 4/1/15, indicated the resident required extensive assistance of 1 or 2 staff members for bed mobility, transfers, toileting, and personal hygiene. The resident was assessed as having a BIMS (Brief Interview for Mental Status) of 10 out of 15, indicating moderate cognitive impairment.</p> <p>The recapitulation of physical's orders dated 5/1/15 - 5/31/15, indicated the resident had an order dated 4/20/15, "Staff to apply compression socks on in the a.m. and off in the p.m...." Compression socks are used to improve circulation for residents having swelling in the legs.</p> <p>The resident had a current care plan with an origination date of 8/9/11, indicating</p>				

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	<p>the resident required assistance with Activities of Daily Living (ADLs) related to weakness and impaired mobility. The interventions included, but were not limited to, an approach 4/23/15, "Staff to donn [put on] compression socks in am [a.m.] doff off [remove] pm [p.m.]...."</p> <p>On 5/15/15 at 4:39 p.m., the Assistant Director of Nursing Services (ADNS) provided the resident profile for Resident #27 and indicated the profile was currently used by the Certified Nursing Assistants (CNAs) as an assignment sheet. The ADNS indicated the profile contained information regarding care to be provided to the resident. The profile indicated the staff should apply compression socks for the resident in the mornings and remove the compression socks in the evenings.</p> <p>On 5/15/15 at 10:30 a.m., the resident was observed up in the wheelchair with one plain black sock on the right foot and was holding a plain black sock. The resident's feet and legs were swollen and dry patches of skin were observed. The resident indicated assistance was needed to get the socks onto both feet.</p> <p>On 5/18/15 at 11:40 a.m., the resident was observed sitting up in a wheelchair in the resident's room. The resident did</p>			

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	<p>not have compression socks in place.</p> <p>On 5/18/15 at 3:30 p.m., the resident was observed sitting up in the wheelchair in the resident room. The resident had plain black socks in place with house slippers on the feet.</p> <p>On 5/19/15 at 9:45 a.m., the resident was observed sitting in the entry way of the resident's room. The resident did not have compression socks in place.</p> <p>On 5/19/15 at 2:00 p.m., the resident was observed sitting in the wheelchair next to the bed. The resident had plain black socks and house slippers on the feet.</p> <p>During an interview with Licensed Practical Nurse (LPN) #6 on 5/19/15 at 2:45 p.m., LPN #6 indicated the resident had an order for compression socks to be applied in the mornings and removed at night. LPN #6 indicated the Treatment Administration Record (TAR) had documentation of the compression socks being applied in the mornings and removed in the evenings.</p> <p>During an interview with the Director of Nursing Services (DNS) on 5/19/15 at 4:45 p.m., the DNS indicated the staff had informed her of the resident having documentation of the compression socks</p>			

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F 0323 SS=D Bldg. 00	<p>being applied and removed each day when in fact the resident did not have compression socks in place.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on observation, interview, and record review, the facility failed to ensure implementation of an assistive device to prevent falls for a resident (Resident # 227).</p> <p>Findings include:</p> <p>The clinical record review for Resident #227, was completed on 5/18/15 at 9:40 a.m. Diagnoses included, but were not limited to, osteoporosis and peripheral vascular disease.</p> <p>A careplan for Resident #227, dated 4/15/15 and updated 4/27/15, indicated resident is at risk for falls. Interventions included, but were not limited to,</p>	F 0323	<p>F- 323 – Accidents</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #227 was found to be in his roommate's wheelchair and was immediately relocated to his wheelchair that had his special wheelchair cushion. <p>Resident #227 wheelchair was immediately labeled with his name in an inconspicuous place for easy identification.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents with assistive devices to prevent falls are at risk for this alleged deficient practice. An audit was completed to 	06/12/2015

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	<p>"...wedge cushion on w/c [wheelchair]...."</p> <p>A review of the ASC (American Seniors Community) Fall Event dated 4/24/15, indicated Resident #227 slid from his wheelchair onto the floor. "...What intervention (s) was put into place to prevent another fall: replaced w/c [wheelchair] cushion with wedge cushion...."</p> <p>A review of the Interdisciplinary Team (IDT) progress noted dated 4/26/15, indicated, "...Immediate intervention was to replace current wheel chair cushion with a wedge cushion to allow resident to position self better in wheel chair, IDT feels the root cause of fall was related to the positioning of the cushion...."</p> <p>A review of the ASC IDT (Interdisciplinary Team) Adaptive Device Review dated 4/28/15, indicated Resident #227 used a wedge cushion to his wheelchair for positioning.</p> <p>During an observation on 5/18/15 at 11:09 a.m., Registered Physical Therapist (RPT) #8 assisted Resident #227 out of the wheelchair the resident was currently sitting in. RPT #8 indicated the wheelchair cushion currently in place was a regular wheelchair cushion.</p>		<p>ensure that residents which require assistive devices related to falls are in place in accordance with their plan of care and noted in the resident profile.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Nursing Staff will be in-serviced regarding implementation of assistive devices per plan of care by Director of Nursing and/or Designee on or before June 12, 2015. ·The Director of Nursing Services and/or designee will complete a daily audit tool each shift of the residents requiring assistive devices related to falls to ensure fall interventions are in place per plan of care. <p>How 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> <ul style="list-style-type: none"> ·Assistive Devices Related to Falls CQI audit tool will be utilized by the Executive Director and/or designee to monitor compliance with use of assistive devices daily X 4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. ·Results of this audit will be presented to the CQI Committee monthly to review for compliance and follow-up. <p>Identified noncompliance may result in staff re-education and/or disciplinary action.</p>	

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F 0329 SS=D Bldg. 00	<p>The current physicians order dated 4/24/15, reviewed on 5/19/15 at 2:39 p.m., indicated "...Order Description: Wedge cushion for positioning Frequency: Every Shift..."</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure a laboratory blood test was done to ensure the level of a medication used for mood stabilization</p>	F 0329	<p>If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</p> <p>F- 329-Drug regimen is free from unnecessary drugs What corrective action(s) will be accomplished for those residents found to have been</p>	06/12/2015

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	<p>was at a therapeutic level (Resident #152) for 1 of 5 residents reviewed for unnecessary medication use.</p> <p>Findings include:</p> <p>The clinical record review for Resident #152, was completed on 5/15/15 at 4:50 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbances.</p> <p>A review of the current physician orders on 5/15/15 at 4:50 p.m., indicated Resident #152 was to receive Depakote Sprinkles 750 mg by mouth twice a day to treat dementia with behavior disturbances.</p> <p>A review of the current Medication Administration Record (MAR) for May 2015, indicated Resident #152 is administered Depakote Sprinkles for dementia with behavior disturbances.</p> <p>A review of a lab order for Resident #152, dated 12/11/14, indicated a valporic acid level (Depakote) was to be drawn on the 4th Friday of January, May, and September.</p> <p>A review of Resident 152's valporic acid level report dated 1/6/15, indicated no valporic acid level for January 2015.</p>		<p>affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #152 physician was notified, order obtained for valproic acid level to be obtained on 5/20/15, results indicated valproic acid was in therapeutic range, valproic acid level was ordered to be drawn Q 6 months. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents who have orders to receive medication that require laboratory evaluation for therapeutic medication levels have the potential to be affected by the alleged deficient practice. All residents who received medication that require laboratory evaluation for therapeutic medication levels were identified and a daily audit by DNS and/or designee has been conducted to ensure labs were obtained per MD order. <p>What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> An in-service will be completed by the Director of Nursing and/or designee by June 12, 2015, for licensed nurses on following MD orders related medications that require laboratory evaluation for therapeutic medication levels. 	

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	<p>During an interview on 5/19/15 at 4:55 p.m., the Director of Nursing Services (DNS), indicated a valporic acid level for Resident #152 was not completed as ordered by physician. The DNS also indicated the valporic acid level to be drawn, per order, was not placed in the lab tracking book.</p> <p>Review of the "GUIDELINES FOR LAB TRACKING", provided by the DNS on 5/20/15 at 11:25 a.m., indicated "...Review MD [Medical Director] orders and place in tracking binder at time order reviewed..."</p> <p>The Lippincott Nursing 2015 Drug Handbook, 35th edition, copy right 2014, indicated nursing considerations for a resident receiving Depakote medication included the need to monitor the drug level.</p> <p>3.1-48(a)(3)</p>		<p>·Noncompliance with physician orders and documentation related to monitoring requirements for medication that require laboratory evaluation for therapeutic medication levels may result in re-education and/or disciplinary action.</p> <p>·An In-service will be completed for licensed nurses by IU Health Laboratory regarding input resident labs and electronic monitoring of scheduled labs and lab results.</p> <p>·The Director of Nursing Services and/or designee will complete a daily audit using facility lab tracking system. Medical Records will monitor MD lab orders to ensure they are inputted into our Electronic Medical Records system. Unit managers will monitor all new lab orders to verify that lab received new orders.</p> <p>How 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>·Following MD Ordered Labs for medications that require laboratory evaluation for therapeutic medication levels CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with obtaining scheduled labs related to medications that require laboratory evaluation for therapeutic medication levels.</p>	

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F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and		Audits will be completed weekly X 4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. ·Results of these evaluation processes will be presented to the CQI Committee monthly to review for compliance and follow-up. Identified noncompliance may result in staff re-education and/or disciplinary action. ·If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up. Compliance date: 06/12/2015	

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	<p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to ensure a reusable machine used to check blood sugars was appropriately cleaned and disinfected between residents for 3 of 3 residents observed for blood sugar checks. (Resident #191, Resident #11, and Resident #144)</p> <p>Findings include:</p> <p>1. During an observation of a blood sugar check on Resident #191 on 5/18/15 at 4:30 p.m., Registered Nurse (RN #5) removed the blood sugar machine from the medication cart and went into the</p>	F 0441	<p>F- 441 – Infection Control What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·The blood glucose monitor for resident#191 was immediately disinfected per Glucose Meter Cleaning and Testing Validation. ·The blood glucose monitor for resident#11 was immediately disinfected Glucose Meter Cleaning and Testing Validation. ·The blood glucose monitor for resident#144 was immediately disinfected Glucose Meter Cleaning and Testing Validation. ·Skills validation “Glucose Meter Cleaning and Testing Validation” was immediately 	06/12/2015

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	<p>resident's room. RN #5 proceeded to check the blood sugar and then returned to the medication cart. RN #5 removed a Super Sani-Cloth from a package and wiped the machine for approximately 5 seconds and then placed the machine on a tissue on the top of the medication cart. RN #5 indicated the machine needed to dry before it could be used on another resident.</p> <p>2. During an observation of a blood sugar check on Resident #11 on 5/18/15 at 4:47 p.m., Licensed Practical Nurse #4 removed the blood sugar machine from the medication cart and proceeded to check the blood sugar of Resident #11. After checking the blood sugar, LPN #4 placed the machine (without sanitizing the machine) into the machine package and placed the machine back into the medication cart.</p> <p>3. During an observation of a blood sugar check on Resident #144 on 5/18/15 at 4:50 p.m., LPN #4 removed the machine from the medication cart and went into the room of Resident #144. LPN #4 prepared to obtain the blood for the test and stopped when asked if the machine was the one used on Resident #144 for the blood sugar check. LPN #4 indicated it was the same machine and returned to the medication cart. LPN #4 removed a</p>		<p>completed for LPN #4 and RN #5</p> <ul style="list-style-type: none"> ·DNS and/or designee immediately provided in-service for licensed nurses on the Glucose Meter Cleaning and Testing Validation. ·Copies of the Glucose Meter Cleaning and Testing Validation were posted on all medication carts. ·Medical carts were immediately provided with timers to ensure compliance with dwell time. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents that require blood glucose monitoring have the potential to be affected by the alleged deficient practice. ·An audit was completed to identify all residents that are currently receiving blood glucose monitoring and a daily audit by DNS and/or designee has been initiated to ensure proper Glucose Meter Cleaning. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Skills validation will be completed by all licensed nursing staff by DNS and/or designee on or before June 12, 2015, for Licensed Nurses on the Glucose Meter Cleaning and Testing Validation. ·Glucose Meter Cleaning and 		

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	<p>Super Sani-Cloth from the cart and proceeded to wipe the machine with the cloth. After wiping the machine for approximately 7 seconds, LPN #4 placed the machine onto a tissue on the medication cart.</p> <p>On 5/18/15 at 5:30 p.m., the Executive Director (ED) and the Director of Nursing Services (DNS) were informed of the observations of the blood sugar checks. The ED and the DNS indicated the nursing staff should have cleaned the machines before and after checking the blood sugars and the nursing staff would be inserviced immediately.</p> <p>At 5:45 p.m., on 5/18/15, the ED provided the Glucose Meter Cleaning and Testing Procedure Validation dated 03/2013, and indicated the procedure was the one currently used by the facility. The procedure indicated, "...Preparation for the procedure...5. Obtain single use germicidal wipe, super sani-cloth. 6. Wipe entire external surface of the blood glucose meter with wipe for 2 minutes...Obtaining blood sugar results...12. Proceed to resident room with cleaned meter...Cleaning meter after use/prior to using on next resident...Obtain single-use germicidal wipe, Super Sani Cloth. Wipe the entire external surface of the blood glucose</p>		<p>TestingValidation will be completed for all licensed nursing staff as part of new hireorientation.</p> <ul style="list-style-type: none"> ·Additional blood glucose monitors weremade available on licensed nurses' medication carts. ·DNS / and or designee will conduct dailymonitoring for each shift to make sure that glucose meter cleaning occurs perGlucose Meter Cleaning and Testing Validation. <p>How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·Glucometer Cleaning CQI audit tool willbe utilized by DNS/designee to observe blood glucose monitor cleaning weekly X4 weeks, monthly X 6 months, and quarterly thereafter for at least two quarters. ·Results of Audit tool will be presentedto the CQI Committee monthly to review for compliance and follow-up. Identifiednoncompliance may result in staff re-education and/or disciplinary action. ·If threshold of 100% is not achieved, anaction plan will be developed to achieve desired threshold. Data will be submitted to the CQI committeefor review and follow up. 	

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	meter with wipe for 2 minutes and ensure meter stays wet for 2 minute time period.... " The directions for use on the Super Sani-Cloth package indicated, "To disinfect and deodorize:...Unfold a clean wipe and thoroughly wet surface. Treated surface must remain visibly wet for two (2) minutes...." 3.1-18(a)				