

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 02/19/2015
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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 000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey and the Investigation of Complaint #IN00164288.</p> <p>Complaint #IN00164288 - Substantiated. Federal /State deficiencies related to the allegations are cited at F224.</p> <p>Survey dates: February 12, 13, 16, 17, 18, 19, 2015.</p> <p>Facility number: 013019 Provider number: 155815 AIM number: 201251520</p> <p>Survey Team: Tom Stauss, RN-TC Beth Walsh, RN Angela Stallsworth, RN Karina Gates, Generalist</p> <p>Census bed type: SNF: 50 SNF/NF: 9 Residential: 27 Total: 86</p> <p>Census payor type: Medicare: 38</p>	F 000	<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 Recertification and State Licensure Survey with Complaint (IN00164288) on February 19, 2015. 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 224 SS=A Bldg. 00	<p>Medicaid: 6 Other: 15 Total: 59</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 24, 2015 by Cheryl Fielden, RN.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 ensure a resident's property was protected from staff misappropriation for 1 of 3 residents reviewed for abuse. (Resident #24)</p> <p>Findings Include:</p> <p>Resident #24's record was reviewed on 2/13/15 at 1:39 p.m. The resident's diagnoses included, but were not limited to, post lumbar surgery, disk decompression, and indicated the resident admitted to the facility on 12/12/14. The resident's medications included, but were</p>	F 224	<p>F 224</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: An investigation for the allegations of staff misappropriation of resident funds and medications was completed. 2 CNAs were terminated for failed drug tests. The resident was refunded the amount of the money missing and medications were re-ordered.</p>	03/21/2015

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	<p>not limited to, oxycodone.</p> <p>A 1/9/15 MDS (Minimum Data Set) assessment indicated Resident #24's BIMS (Brief Interview of Mental Status) score was "15" which indicated the resident did not have a cognitive impairment.</p> <p>An "Incident Report Form", dated 1/29/15, indicated Resident #24 alleged CNA's (Certified Nursing Assistant) #4 and #5 took "Vicodin (a narcotic pain medication containing hydrocodone) and money." The report stated both CNA's were suspended pending an investigation and both sent for a drug screen.</p> <p>A lab form, dated 1/29/15, indicated a drug screen (urinalysis) was performed on CNA #4 and CNA #5.</p> <p>On 2/13/15 at 1:40 p.m., during an interview, the Administrator indicated CNA's #4 and #5, were suspended on 1/29/15 pending an investigation. The administrator indicated sending CNA's #4 and #5 for a drug screen on 1/29/15, at which CNA #4 tested positive for hydrocodone (a narcotic medication used in the preparation of Vicodin) and CNA #5 tested positive for a different substance. The Administrator indicated the facility terminated CNA's #4 and #5</p>		<p>This allegation was reported to the ISDH prior to the annual survey.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by the same alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: The campus staff was re-educated on the guideline for Abuse and Neglect. The campus will continue the process to screen employees prior to hire for history of abuse, train the new employees on abuse prevention, including training on protection of the resident, investigation of the alleged abuse and reporting the suspected abuse.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 3 residents and 3 staff members will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4</p>	

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	<p>on 2/2/15 for failed drug tests.</p> <p>The 1/29/15 facility investigation for the incident involving Resident #24 was provided by the Administrator on 2/12/15, at 11:00 a.m. It included a written statement by the DHS (Director of Health Services), which indicated Resident #24 was interviewed about the missing property on 1/29/15. The statement indicated Resident #24 "...has seen her (CNA #4) coming out of his room when he's not in there..."</p> <p>Nursing progress notes, dated 1/29/15 indicated resident was discharged to another facility, with a 3 day supply of medications. The resident's son signed for the resident's narcotic medications.</p> <p>An "EMPLOYEE AFFIRMATION OF COMPLIANCE" form, dated 11/4/14, indicated CNA #4 received a copy of the "Employee Standards and Code of Ethical Conduct", a facility policy. The CNA also signed the facility Abuse policy on 11/4/14, which included identifying Misappropriation of Property as a form of resident abuse.</p> <p>On 2/16/15 at 3:27 p.m., during an interview, Resident #24 indicated he had "pain pills and money" stolen by facility staff members. He indicated the property</p>		<p>months to ensure compliance: Interviews for residents regarding protection from staff misappropriation. Interviews for staff regarding Abuse and Neglect (includes misappropriation, training, investigation and reporting suspected abuse)</p> <p>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 278	<p>was taken "at least two weeks before I left" the facility. He indicated he did not notify staff at the time the incident occurred because "I didn't think they would do anything about it." He recalled telling facility staff about the incident shortly before he discharged from the facility. The resident indicated his property that went missing was in a plastic bag in his locked bedside table/nightstand. He indicated the facility returned the \$200 on the day he left, which he identified as 1/29/15, but not the Norco.</p> <p>A facility abuse policy, dated 11/2010 and titled "ABUSE AND NEGLECT", defined "MISAPPROPRIATION OF PROPERTY" as "...the deliberate, misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or funds..." The policy described facility processes in place to screen employees prior to hire for "...history of abuse...", train the new employees on abuse prevention, including training on protection of the resident, investigation of the alleged abuse, and reporting the suspected abuse.</p> <p>3.1-28(a)</p> <p>483.20(g) - (j)</p>			

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SS=A Bldg. 00	<p>ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure a MDS (minimum data set) assessment was accurate for 1 of 17 residents reviewed for assessments. (Resident #114)</p> <p>Findings include: The clinical record for Resident #114 was</p>	F 278	<p>F 278</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #114 has been discharged. The inaccurate</p>	03/21/2015

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	<p>reviewed on 2/16/15 at 1:45 p.m. The diagnoses for Resident #114 included, but were not limited to, diabetes mellitus, pneumonia, acute encephalopathy, and septic left knee.</p> <p>The Admission MDS (minimum data set) assessment, dated 11/18/14, indicated, "...Prognosis. Does the Resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician documentation)." The assessment was marked "no" for the question.</p> <p>The MDS assessments dated 11/25/14, 12/9/14, and 12/17/14 indicated "yes" to the above prognosis question.</p> <p>There was no physician documentation in the clinical record indicating Resident #114 had a condition or chronic disease that may result in a life expectancy of less than 6 months.</p> <p>During an interview with the Campus Support Resident Assessment staff member, on 2/17/15 at 2:37 p.m., she indicated the MDS assessments dated 11/25/14, 12/9/14, and 12/17/14 were filled out incorrectly related to the prognosis question.</p> <p>3.1-31(d)</p>		<p>MDS for this resident dated 11/25/14, 12/9/14 and 12/17/14 were modified to reflect the accuracy for the question related to Prognosis and life expectancy with less than 6 months to live.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: The MDS Coordinator will review the most recent MDS of residents to ensure the accuracy for the question related to Prognosis and life expectancy with less than 6 months to live.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: MDS Coordinator will re-educate the MDS staff on completion of the MDS with accuracy.</p> <p>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 MDS Coordinator or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Accuracy for the question related to Prognosis and life expectancy with less than 6 months to live.</p>	

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F 279 SS=D Bldg. 00	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under</p>		<p>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>§483.10(b)(4). Based on interview and record review, the facility failed to ensure a care plan was created for a resident who received anticoagulant medication. This affected 1 of 27 residents reviewed for care plans. (Resident #14)</p> <p>Findings Include:</p> <p>Resident #14's record was reviewed on 2/12/15 at 11:19 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation, dementia, CHF, generalized weakness. The resident's medications included, but were not limited to, coumadin (an anticoagulant, also known as warfarin).</p> <p>MDS (Minimum Data Set) assessments, dated 12/9/14, 12/16/14, and 12/30/14 indicated Resident #14 received anticoagulant medication.</p> <p>Physician's admission orders, dated 10/7/14, indicated Resident #14 received warfarin (an anticoagulant medication). The orders also directed staff to monitor the resident for bleeding gums, excess bruising, and bleeding.</p> <p>On 2/17/15 at 3:13 p.m., during an interview, the DHS (Director of Health Services) indicated Resident #14 did not</p>	F 279	<p>F 279</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #14 - care plan was developed related to anticoagulant therapy.</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 residents with anticoagulant therapy to ensure a care plan is in place.</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 Interdisciplinary Team on the following campus guidelines: 1). Care Plans 2). Anticoagulant Therapy Medication</p>	03/21/2015

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F 329 SS=E Bldg. 00	<p>have an anticoagulant therapy care plan in place. He indicated staff was monitoring the resident for complications of the anticoagulant therapy, but for some reason a care plan was not in place. He indicated the MDS department usually would initiate a care plan for anticoagulant therapy if the resident was admitted on an anticoagulant.</p> <p>On 2/18/15 at 9:31 a.m., during an interview, the MDS Coordinator indicated Resident #14 did not have a care plan in place for anticoagulant therapy since his admission to the facility on 12/2/14.</p> <p>An undated facility policy on anticoagulant medication therapy, received on 2/18/15 at 11:15 a.m., from the Director of Health Services, indicated "...The resident should have a plan of care that addresses the anticoagulant (Coumadin, Heparin, Lovenox) and monitoring for side effects..."</p> <p>3.1-35(b)(1)</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</p>		<p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits 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 all residents receiving anticoagulant therapy to ensure a comprehensive plan of care has been developed.</p> <p>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>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 pre-assessments and post assessments were completed prior to administration of PRN (as needed) pain medication for 4 of 5 residents reviewed for unnecessary medication. (Resident #'s 39, 129, 136 147) The facility also failed to ensure non-pharmalogical approaches were attempted prior to the administration of PRN anti-anxiety medication for 1 of 5 residents reviewed for unnecessary medication. (Resident #136)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #147 was reviewed on 2/13/15 at 2:15 p.m.</p>	F 329	<p>F 329</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #39, 129, 136 and 147 - all have been discharged from the campus.</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 the following: 1). All residents with an order for PRN pain medication to ensure pre-assessments and</p>	03/21/2015

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	<p>The diagnoses for Resident #147 included, but were not limited to, diabetes mellitus, chronic pain, and acute renal failure. Resident #147 was admitted on 2/6/15.</p> <p>The Admission Physician Orders indicated an order for oxycodone (narcotic for pain) 10 mg (milligrams) by mouth every 4 hours as needed (PRN) for pain.</p> <p>The February MAR (medication administration record) indicated Resident #147 received oxycodone on the following dates: 2/7/15-no time, 2/7/15-no time (pulled from the emergency drug kit), 2/10/15-no time, 2/15/15 at 9:30 a.m., and 2/15/15-9:00 p.m.</p> <p>A Nurse's Note, dated 2/7/15 at 9:00 a.m., indicated Resident #147 had surgical site pain and PRN oxycodone was administered. A Nurse's Note, dated 2/7/15 at 9:45 a.m., indicated the medication was effective.</p> <p>The back of the MAR indicated oxycodone was given once on 2/15/15 (no time) for a complaint of pain and the medication was effective.</p>		<p>post assessments have been completed prior to administration of PRN pain medication. 2). All residents with an order for PRN anti-anxiety medication to ensure non-pharmalogical approaches were attempted prior to administration of the medication.</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 campus guidelines: 1). Administration of PRN Medications 2). PRN Medication Tracking Log</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits 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: 1). Review of residents with an order for / received PRN pain medication to ensure pre-assessments and post assessments have been completed prior to administration of PRN pain medication. 2). Review of residents with an order</p>	

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	<p>Documentation for the indication for the need and the effectiveness of the oxycodone for one administration on 2/7/15, 2/10/15, and one administration on 2/15/15 was not located in the clinical record.</p> <p>During an interview with the Director of Health Services (DHS), on 2/16/15 at 10:36 a.m., the DHS indicated Nursing Staff should indicate the reason/need for the administration of PRN pain medication and the effectiveness of the medication in the clinical record.</p> <p>The DHS indicated, on 2/16/15 at 11:20 a.m., he was unable to locate documentation for the need of oxycodone and the effectiveness of the medication administered on the 3 dates above.</p> <p>A policy titled, Administration of PRN Medication Guideline, no date, was received from the DHS, on 2/16/15 at 10:44 a.m. The policy indicated, "...3. Documentation should reflect the reason for administering the PRN medication. a. i.e.: c/o [complaint of] of [sic] headache,...wringing hands, c/o of [sic] hip pain....5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects."</p>		<p>for / received PRN anti-anxiety medication to ensure non-pharmalogical approaches were attempted prior to administration of the medication.</p> <p>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>2. The clinical record for Resident #39 was reviewed on 2/12/15, at 2:47 p.m. The diagnoses for Resident #39, included, but were not limited to, intractable back pain and diskitis.</p> <p>The February, 2015 Physician's Orders indicated a prn (as needed) Norco (pain medication) tablet to be given every 4 hours for mild to moderate pain, and 2 tablets every 4 hours for severe pain, effective 1/8/15.</p> <p>The January, 2015 MAR (medication administration record) for Resident #39 indicated she was given prn Norco on the following dates: 1/10/15, 1/12/15, 1/17/15, 1/20/15, 1/23/15, and 1/24/15.</p> <p>The reason for the above administrations, the intensity of the pain prior to the administrations, the interventions tried prior to the administrations, and the effectiveness of the above administrations were not found on the back of the MAR, in the nurses notes, on the PRN Medication Tracking log, or anywhere else in the clinical record.</p> <p>An interview was conducted with LPN #2 on 2/17/15, at 10:25 a.m. She indicated the pain assessments should be documented on the back of the MAR or the PRN Medication Tracking log.</p>			

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	<p>An interview was conducted with the DHS (Director of Health Services) on 2/17/15, at 10:29 a.m. He indicated, "They (nursing) should be documenting the assessments for pain on the yellow prn sheet (PRN Medication Tracking log).</p> <p>3. The clinical record for Resident #136's clinical record was reviewed on 2/16/15 at 11:00 a.m. The diagnoses for Resident #136 included, but were not limited to, right knee osteoarthritis and right knee pain.</p> <p>A physician's order, dated on 2/5/14, indicated to administer 1 milligram of Ativan by mouth every 4 hours as needed (PRN) for anxiety.</p> <p>Resident #136's "Individual Patient's Narcotics Record" indicated the Ativan was administered on the following days:</p> <p>2/5/15 given at 11 p.m., 2/6/15 given at 9:30 a.m., 2/6/15 given at 10 p.m., 2/7/15 given at 10:30 p.m., 2/8/15 given at 10:25 p.m., 2/9/15 given at 9:45 a.m., 2/9/15 given, no time, 2/10/15 given at 10 p.m., 2/11/15 given at 9:30 a.m. & 2/12/15 given at 9:15 a.m.</p>			

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	<p>The "PRN Medication Tracking" record indicated on 2/7/15 at 1:45 p.m., four interventions (bed rest, 1:1 time, reassurance, position for comfort) were attempted before Ativan was given to Resident #136. On 2/8/15 at 10:25 p.m. three interventions (reassurance, bed rest, diversion) were attempted before Ativan was administered. There were no interventions noted for the following days of administration of Ativan:</p> <p>2/5/15 given at 11:00 p.m., 2/6/15 given at 9:30 p.m., 2/6/15 given at 10:00 p.m., 2/7/15 given at 10:30 p.m., 2/9/15 given at 9:45 a.m., 2/9/15 given, no time, 2/10/15 given at 10:00 a.m., 2/11/15 given at 9:30 a.m. & 2/12/15 given at 9:15 a.m.</p> <p>An interview was conducted with the Director Health Services (DHS) on 2/16/15 at 1:00 p.m. He indicated interventions should be documented on the PRN medication tracking record or a progress note.</p> <p>A facility policy, titled "Administration of PRN Medications Guideline" indicated "...Procedure:.2. Non-pharmacological interventions (i.e. activity, food,</p>			

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	<p>re-direction, emotional support, position for comfort or other interventions as defined on the individualized plan of care) shall be attempted and documented prior to administration of PRN medications..."</p> <p>4. Resident #129's record was reviewed on 2/12/15 at 11:44 a.m. The resident's diagnoses included, but were not limited to, CHF, stroke history, BPH, depression, and COPD. It indicated the resident admitted to the facility on 1/30/15.</p> <p>Physician's orders, dated 2/4/15, indicated for Resident #129 to receive Norco (a narcotic pain medication) 5/325 (1 tablet) by mouth every 4 hours as needed for mild pain and 2 tablets of the same medication every 4 hours as needed for moderate to severe pain.</p> <p>Resident #129's pain care plan, dated 2/10/15, indicated "...Before you medicate me, attempt non-pharmacological interventions of repositioning, relaxation, distractions..."</p> <p>The medication administration record indicated Resident #129 received Norco 5/325 (2 tablets) on 2/5/15, 2/9/15, 2/11/15, 2/14/15, and 2/16/15. The record showed the resident received Norco 5/325 (1 tablet) on 2/15/15. The record did not have non-pharmacological</p>			

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	<p>interventions indicated prior to the administration of the pain medication administrations above.</p> <p>On 2/16/15 at 1:12 p.m., during an interview, LPN #6 indicated nursing staff attempts to use non pharmacologic interventions prior to PRN medication administration for any resident. She indicated staff uses those medications as a "last resort."</p> <p>On 2/17/15 at 10:00 a.m., during an interview, the DHS (Director of Health Services) indicated nursing staff should attempt non-pharmacological interventions prior to PRN pain medication administration. He was unable to provide evidence nursing staff attempted non-pharmacological interventions prior to Resident #129 receiving the pain medications as listed above.</p> <p>An undated facility policy, titled "ADMINISTRATION OF PRN MEDICATIONS GUIDELINE" indicated "...Non-pharmacological interventions (i.e. activity, food, re-direction, emotional support, position for comfort or other interventions as defined on the individualized plan of care) shall be attempted and documented prior to administration of PRN medications..."</p>			

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F 371 SS=F Bldg. 00	<p>3.1-48(a)(6)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure refrigerated food was covered, and bread was stored in closed packaging. This had the potential to affect 55 residents who eat food from the kitchen of 59 residents in the facility.</p> <p>Findings include: A tour of the kitchen was conducted on 2/12/15, at 10:00 am.</p> <p>The bread was stored in stacking, vertical bins. The top shelf contained 2 hard, exposed hot dog buns, not sealed or packaged. The refrigerator near the steam table was observed with a package of open bacon, with bacon spilled out of the package and resting on the shelf, exposed to air. A package of American cheese and a package of Swiss cheese were observed open and exposed to air.</p>	F 371	<p>F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Audit of all refrigerated food to ensure the food is covered. 2). Audit of all dry storage to ensure it is stored in closed packaging. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: Storage Procedures How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The</p>	03/21/2015

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F 441 SS=D Bldg. 00	<p>The Food Services Director (FSD) indicated the 2 hot dog buns should not have been there, and the packages of cheese should have been sealed.</p> <p>An interview was conducted with the dietary department's Regional Campus Support person on 2/12/15, at 12:51 p.m. He indicated the hot dog buns should not have been exposed, and the cheese should have been wrapped in saran wrap.</p> <p>The Storage Procedures policy was provided by the FSD on 2/18/15, at 11:00 a.m. It indicated, "Dry Storage of Food...Open packages are labeled, dated, and stored in closed containers....Refrigerated Storage...Food is covered, dated and stored loosely to permit air circulation."</p> <p>3.1-21(i)(3)</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p>		<p>following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Audit of all refrigerated food to ensure the food is covered. 2). Audit of all dry storage to ensure it is stored in closed packaging. 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>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 properly disinfect a glucometer (machine used for readings of blood glucose/sugar levels) during 1 of 2 residents observed for blood sugar testing. (Resident #128) The facility also failed to wash hands/don gloves prior to touching a resident's medication for 1 of 5 residents observed for medication administration. (Resident #34)</p>	F 441	<p>F 441</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Resident #128 glucometer machine was disinfected with Germicidal Wipe per manufacture instructions.). Resident #34 - LPN#2 was immediately coached / educated</p>	03/21/2015

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	<p>Findings include:</p> <p>1. An observation of blood sugar testing for Resident #28 was done, on 2/16/15 at 11:00 a.m., with LPN #1. LPN #1 performed the blood sugar testing on Resident #28 and wiped the glucometer for 5 seconds with a [Name of Company] Germicidal Disposable Wipe and the glucometer quickly dried within 15 seconds. LPN #1 then took the glucometer to the medication cart and wiped the glucometer again for 5 seconds and the glucometer quickly dried within 15 seconds. LPN #1 went into Resident #128's room, on 2/16/15 at 11:16 a.m., and placed the glucometer on the console table. LPN #1 proceeded to prepare the glucometer for blood glucose testing, by placing the blood glucose testing strip into the glucometer and wiping Resident #128's finger with an alcohol pad. LPN #1 picked up the blood glucose needle to obtain a sample of blood and was holding Resident #128's finger out to be pricked by the needle. Prior to pricking Resident #128's finger, LPN #1 indicated she was unaware of how long the glucometer needed to be visibly wet from the [name of company] Germicidal Disposable Wipe. LPN #1 then proceeded to wipe the glucometer again for 10 seconds and the glucometer quickly dried within 15 seconds. LPN #1 picked up the blood</p>		<p>after this alleged deficient practice regarding the requirement of washing hands with soap and water or alcohol gel and don gloves prior to handling tablets, according to the Medication Administration General Guidelines.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: 1). DHS or designee will clean all glucometers with Germicidal Wipe per manufacture instructions. 2). All residents have the potential to be affected by the same alleged deficient practice.</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: 1). Glucometer Cleaning Guideline 2). Germicidal Wipe package instructions 3). Medication Administration - General Guidelines (education to include QMAs)</p> <p>How the corrective measures will be monitored to ensure the</p>	

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	<p>glucose needle again to obtain a sample of blood and was holding Resident #128's finger out to be pricked by the needle. Prior to pricking Resident #128's finger, LPN #1 reviewed the [name of company] Germicidal Disposable Wipe packaging and proceeded to wipe the glucometer for 3 minutes. LPN #1 then proceeded to perform the blood sugar testing for Resident #128.</p> <p>A review of the [name of company] Germicidal Disposable Wipe packaging indicated, "...To Disinfect:...Treated surface must remain visibly wet for a full three (3) minutes. Use additional wipe(s) if needed to assure continuous 3 minute wet contact time...."</p> <p>A policy titled, Glucometer Cleaning Guidelines, no date, was received from the Director of Health Services (DHS) on 2/16/15 at 1:05 p.m. The policy indicated, "...Recommendations: 1. If glucometers are used from one resident to another they should be cleaned and disinfected after each use....3. If no visible organic material is present, disinfect after each use the exterior surfaces [sic] following the manufacturer's directions...."</p> <p>During an interview with the DHS, on 2/16/15 at 10:15 a.m., the DHS indicated</p>		<p>alleged deficient practice does not recur: The following observations for 5 residents, random shifts will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Observe accu check to ensure glucometer machine is cleaned appropriately with a Germicidal Wipe per package instructions. 2). A med pass observation will be conducted on 3 licensed nurses or QMAs to ensure hand washing / use of alcohol gel and use of gloves if there is a need to handle oral/tablet medications.</p> <p>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>the glucometer needed to be disinfected as indicated by the manufacturer's instructions on the[name of company] Germicidal Disposable Wipe packaging.</p> <p>2. During an observation of medication administration with LPN #2, on 2/16/15 at 8:53 a.m., for Resident #34, Resident #34 indicated she would like her potassium chloride 10 meq (milliequivalents) pill split in half. LPN #2 picked up the potassium chloride pill with her bare hand, without washing or gloving her hand, and placed the pill in a pill cutter. LPN #2 then proceeded to pick up the two halves of the pill out of the pill cutter, after the pill was split, with her bare hand and placed the pills on a tissue. Resident #34 then picked up the split medication from the tissue and swallowed the medication.</p> <p>During an interview with LPN #2, on 2/16/15 at 10:30 p.m., LPN #2 indicated she typically wears gloves prior to touching a Resident's medication.</p> <p>The Director of Health Services (DHS) indicated, on 2/16/15 at 10:40 a.m., Nursing Staff should wear gloves prior to touching a Resident's medication.</p> <p>A policy titled, Medication Administration-General Guidelines, no</p>			

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F 999 Bldg. 00	<p>date, was received from the DHS on 2/17/15 at 11:00 a.m. The policy indicated, "...4) If breaking tablets is necessary to administer the proper dose, hands are washed with soap and water, alcohol gel or gloved prior to handling tablets...."</p> <p>3.1-18(a)</p> <p>3.1-14 PERSONNEL (q) Each facility shall maintain current and accurate personnel records for all employees. The personnel records for all employees shall include the following: (5) Professional licensure, certification, or registration number or dining assistant certification or letter of completion if applicable.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure a certified residential care associate (CRCA/CNA-certified nursing assistant) maintained an active license for 1 of 26 CRCA's reviewed for appropriate certification. (CRCA #7)</p>	F 999	<p>F 9999</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: CRCA #7 has a current certification on file.</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 employed CRCA's to ensure they have a current certification on file.</p> <p>Measures put in place and</p>	03/21/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 000 Bldg. 00	<p>An interview was conducted with the AP/Payroll Coordinator on 2/19/15 on 9:48 a.m. She indicated CRCA #7 license had been expired since 12/17/14.</p> <p>CRCA #7 's timesheets was provided by the AP/Payroll Coordinator on 2/19/15 at 10:30 a.m. These timesheets indicated from 12/17/14 thru 2/14/15 CRCA #7 had worked in the facility a total of 35 days since the expiration of her license.</p> <p>A facility policy, titled "Licensure and Registration of Personnel" was provided by the Director Health Services (DON) on 2/19/15 at 11:10 a.m. This policy indicated, "...Policy Interpretation and Implementation...2. A copy of the current license and registration number must be filed in the employee's personnel record..."</p> <p>The following Residential Findings were</p>	R 000	<p>systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing Leadership team on the following: Licensure and Registration of Personnel</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 CRCAs will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Review certification on file to ensure it is current.</p> <p>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> <p>Preparation or execution of this plan of correction does not constitute</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155815	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2015
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R 273 Bldg. 00	<p>cited in accordance with 410 IAC 16.2-5</p> <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. Based on observation, interview, and record review, the facility failed to ensure refrigerated food was covered, and bread was stored in closed packaging. This had the potential to affect 27 residents who</p>	R 273	<p>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 Recertification and State Licensure Survey with Complaint (IN00164288) on February 19, 2015. 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> <p>R 273 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: 1). Audit of all refrigerated food to ensure the food is covered. 2). Audit of</p>	03/21/2015

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	<p>eat food from the kitchen of 27 residents in the facility.</p> <p>Findings include:</p> <p>A tour of the kitchen was conducted on 2/12/15, at 10:00 am with the FSD (Food Services Director).</p> <p>The bread was stored in stacking, vertical bins. The top shelf contained 2 hard, exposed hot dog buns, not sealed or packaged. The refrigerator near the steam table was observed with a package of open bacon, with bacon spilled out of the package and resting on the shelf, exposed to air. A package of American cheese and a package of Swiss cheese were observed open and exposed to air. The FSD indicated the 2 hot dog buns should not have been there, and the packages of cheese should have been sealed.</p> <p>An interview was conducted with the dietary department's Regional Campus Support person on 2/12/15, at 12:51 p.m. He indicated the hot dog buns should not have been exposed, and the cheese should have been wrapped in saran wrap.</p> <p>The Storage Procedures policy was provided by the FSD on 2/18/15, at 11:00 a.m. It indicated, "Dry Storage of</p>		<p>all dry storage to ensure it is stored in closed packaging.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: Storage Procedures 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 Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Audit of all refrigerated food to ensure the food is covered. 2). Audit of all dry storage to ensure it is stored in closed packaging. 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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	Food...Open packages are labeled, dated, and stored in closed containers....Refrigerated Storage...Food is covered, dated and stored loosely to permit air circulation."				