STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 05/05/2014

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HEARTH AT STONES CROSSING LLC THE	2339 S SR 135 GREENWOOD, IN 46143

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R000000	This visit was for a State Residential Licensure Survey. Survey dates: May 1, 2, and 5, 2014 Facility number: 005722 Provider number: 005722 AIM number: N/A Survey team: Karyn Homan, RN-TC Marsha Smith, RN Dorothy Plummer, RN Patsy Allen, SW Census bed type: Residential: 126 Total: 126 Census payor type: Other: 126 Total: 126 Residential sample: 09 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 12, 2014; by Kimberly Perigo, RN.	R000000	The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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R000092	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift. This had the potential to affect 126 residents who reside in the facility. Findings include: Review of Hearth Management Fire Drill documentation on 5/1/14 at 1:00 p.m., the	R000092	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. 3. A facility schedule has been created to ensure fire	06/05/2014

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	facility lacked documentation required fire drills were conducted during the third shift (11:00 p.m. to 7:00 a.m.) for the third quarter (July, August, and September) of 2013, the second shift (3:00 p.m. to 11:00 p.m.) for the fourth quarter (October, November, and December) of 2013, and the third shift for the first quarter (January, February, and March) of 2014. Interview with Administrator on 5/1/14 at 3:30 p.m., she indicated they did not have documentation of the missing fire drills. The facility had provided all the documentation on fire drills they had.		drills are conducted quarterly on each shift to include at least 12 drills yearly. Executive Director will train the Maintenance Director regarding purpose and ongoing schedule for fire drills on May 27, 2014. 4. The Executive Director and/or designee will conduct a review of completed fire drills to ensure compliance with facility schedule monthly x3 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. 5. These systematic changes will be completed by 6/5/14	
R000217	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual			

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	resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure a resident who self-administered her own medications was evaluated for her ability to safely do so, for 1 of 2 residents reviewed for self medication administration evaluations in a sample of 9. (Resident #90) Findings include: The clinical record of Resident #90 was reviewed on 5/2/14 at 8:50 a.m. Diagnoses included, but were not limited to, hypothyroidism, depression, vitamin D deficiency, and chronic leg pain.	R000217	1. Resident #90 was assessed and passed her self-medication administration evaluation on 5/2/14. A physician order was received on 5/2/14 indicating resident can self administer her own meds 2. Residents who self-administer their own medications have the potential to be affected by	06/05/2014

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	Resident #90 was admitted to the facility on 1/17/13. A service plan, dated 1/14/13, indicated she was independent with her medication management and her family would assist her with this. A nurse's note dated 8/23/13 at 8:40 a.m., indicated Resident #90 was taken to the hospital for evaluation due to a fall. On that date at 3:00 p.m., a nurse's note indicated the resident returned to the facility. A nurse's note on that date at 6:15 p.m., indicated Resident #90's daughter requested nursing to administer the resident's medications. A physician's order on that date indicated nursing was to administer the resident's medications. Review of a Medication Administration Record for August, 2013, indicated Resident #90's medications were administered by the nursing staff 8/23/13 - 8/31/13. A service plan, dated 8/26/13, indicated Resident #90, "Requires staff or family to order, and staff to store and dispense medications." Medication Administration Records for September, October, November, December, 2013, and January, February, March, and April, 2014, did not indicate		this alleged deficient practice. An audit of these residents will be completed to ensure an evaluation of each resident's ability to safely self-administer medications has been completed and a physician order has been obtained. 3. Nurses will evaluate residents requesting to self-administer medications prior to admission and at least once quarterly thereafter. For residents who pass the self medication evaluation, their physician will be notified to obtain an order. Training will be conducted by the DON and Regional Director of Clinical Services for all nurses and QMA's on the facility policy for resident self medication during the week of June 2nd, 2014. 4. The DON and/or designee will conduct a review of residents who self-administer medications to ensure compliance with facility policy monthly x3	

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	the nursing staff was administering Resident #90's medications. A service plan dated November, 2013, indicated Resident #90 was, "Independent with medication management. Has passed the self med[ication] administration assessment with licensed personnel." No documentation was found in the resident's record, which indicated she had been assessed for her ability to safely and independently administer her own medications. During an interview with the Director of Nursing on 5/5/14 at 10:10 a.m., she indicated no self administration assessments had been done for Resident #90 since 8/23/13. She indicated there was no physician's order for the resident to resume self administering her own medications after 8/23/13. On 5/5/14 at 9:30 a.m., she provided a physician's order dated 5/2/14, which indicated Resident #90 could self administer her own medications. On 5/5/14 at 11:35 a.m., the Director of Nursing provided a policy, dated 12/5/2012, regarding self administration of medications, and indicated the policy was the one currently used by the facility.		months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. 5. These systematic changes will be completed by 6/5/14	

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	The policy indicated, "It is the Policy of Hearth Management to ensure that all residents with the ability to self-administer medications are afforded the opportunity to do so, while ensuring the safety and well-being of all residents...1. The physician must state that the resident is able to self administer medications...3. The resident must be able to correctly read the label on the medication container, correctly interpret the label...correctly follow instructions as to the route, time, dosage, frequency...4. Staff members are responsible for evaluating residents who self-administer medication prior to admission and at least once quarterly to ensure their continued compliance...6. For residents who have others setting up their medication...the person setting up the medication and the resident must be evaluated by nursing staff to ensure medications will be set up and taken appropriately."			
R000298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;			

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	(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to document the reconciliation of narcotic medications in 3 of 3 medication carts reviewed for medication storage. Findings include: 1.) During a review of the medication cart Assisted Living Cart #1 on 5/2/14, at 11:20 a.m., the "Narcotic Count Sheets" lacked signatures for 4 of 4 shifts for May 2014, indicating narcotic counts were not completed. The "Narcotic Count Sheets" for April 2014 lacked 77 signatures. LPN #1 indicated staff should have signed each shift when narcotic counts were completed. 2.) During a review of the medication cart Assisted Living Cart #2 on 5/2/14 at 11:30 a.m., the "Narcotic Count Sheets" for April 2014 lacked signatures for 34 shifts, indicating narcotic counts were not completed. LPN #1 indicated staff should have signed each shift when narcotic counts were completed. 3.) During a review of the medication	R000298	1. No residents were affected by the alleged deficient practice. 2. All residents have the potential to be affected by this alleged deficient practice. On May 21, 2014 a narcotic count of 3 of 3 medication carts was completed by DON with no discrepancies noted of narcotics. 3. A reconciliation of narcotic medications will be completed by nurses and QMA's at the beginning of each shift and documented on the Narcotic Count Sheet. Training will be conducted by the DON and Regional Director of Clinical Services for all nurses and QMA's on facility policies and procedures for narcotic reconciliation during the week of June 2nd, 2014.	06/05/2014

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	cart on Keepsake Village on 5/2/14 at 11:45 a.m., the "Narcotic Count Sheets" for April 2014 lacked a signature for 4/28/14, indicating narcotic counts were not completed. During an interview with the Director of Nursing (DoN) on 5/2/14 at 1:30 p.m., the DoN indicated the staff should sign the "Narcotic Count Sheets" when the count was completed at the beginning of each shift and should indicate if the count was accurate. On 5/5/14 at 11:35 a.m., the DoN provided a procedure dated 12/5/12, titled "Narcotics Policy." The DoN indicated the policy was the policy currently used by the facility. "Narcotics Policy...3. Each shift will perform a narcotic count consisting of one oncoming and one off-going staff member. Any discrepancy in narcotic count will be reported to the Director of Nursing/SALSA/Case Manager immediately...."		4. The DON and/or designee will conduct an audit of the narcotic count sheets for all medication carts to ensure compliance with the required reconciliation process weekly x4 weeks, monthly x2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. 5. These systematic changes will be completed by 6/5/14	
R000306	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information:			

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	(1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to ensure a discharged resident's medications were disposed of and documented in the clinical record, as indicated by facility policy, for 1 of 2 residents reviewed for disposition of medications in a sample of 9. (Resident #127) Findings include: The clinical record of Resident #127 was reviewed on 5/1/14 at 2:40 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, high blood pressure, neuropathy, peripheral vascular disease, depression, and anxiety. Resident #127 was discharged from the facility to a hospital on 11/20/13. She did not return to the facility. Recapitulated physician's orders for November, 2013, indicated Resident	R000306	1. Resident #127 was a closed record review and resident no longer resides at facility. 2. All residents who have discharged from the facility have the potential to be affected by this alleged deficient practice. A review of residents who have discharged from the facility within the past 30 days will be conducted by DON and Case Manager to ensure that a disposition of medications has occurred and been documented in the clinical record. Any deficiencies identified during this review will be immediately corrected. 3. For residents who discharge from our facility as	06/05/2014

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	#127's medications at the time of her discharge included, but were not limited to, Plavix (an anti-coagulant), Neurontin (an anticonvulsant), Amaryl (an anti-diabetic), Humalog insulin (an antidiabetic), Lantus insulin (an antidiabetic), Zestril (a medication for high blood pressure), pravastatin (a medication for high cholesterol), Seroquel (an antipsychotic), verapamil (a medication for high blood pressure), and Effexor (an antidepressant). The record did not indicate what the facility had done with Resident #127's medications after she was discharged. On 5/2/14 at 10:00 a.m., the Director of Nursing indicated she was unable to find any information regarding the disposition of Resident #127's medications after she was discharged from the facility. On 5/5/14 at 12:38 p.m., the Director of Nursing provided an undated Disposal of Medications policy and indicated the policy was the one currently used by the facility. The policy indicated, "Disposal of all medications is documented on the Medication Disposition record. Documentation includes: Resident's name, prescription number, name and strength of medication, quantity of medication destroyed, reason for		of 5/5/14, the disposition for any released, returned or destroyed medications will be documented on the Medication Disposition form. Training will be conducted by the DON and Regional Director of Clinical Services for all nurses and QMA's on facility policies and procedures for medication disposition during the week of June 2nd, 2014. 4. The DON and/or designee will conduct an audit of all discharged residents from 5/5/14 and going forward to ensure compliance with medication disposition requirements monthly x3 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. 5. These systematic changes will be completed by 6/5/14	

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	disposal, method of disposal, signature of person conducting the disposal of the drug, signatures of witnesses and date of disposal...Medications should be destroyed before disposal to ensure that they cannot be used or consumed..."			
R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records contained documentation regarding residents' blood glucose monitoring with physician notifications (Resident #106), semi-annual weights (Residents #127, #90, #48 and #47), diet (Resident #48), diagnoses (Resident #48), and laboratory monitoring (Resident #100) for 6 of 9 resident records reviewed for having accurate and complete documentation. Findings include: 1. The clinical record of Resident #106 was reviewed on 5/1/14 at 2:20 p.m.	R000349	1. Resident #106 was assessed with no signs/symptoms of hypo-/hyperglycemia. The physician for resident #106 was contacted and orders received to clarify blood glucose notification parameters. Resident #127 was a closed record review and resident no longer resides at facility. Current weights were obtained for residents' #90, #48 & # 47. Diagnoses and current diet order were obtained from the physician for resident #48. Lab testing for resident #100, including a CBC and FLP, was completed as ordered on 05/05/14. 2. All residents have the potential to be affected by this alleged deficient practice. An audit of resident medical records	06/05/2014

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	Diagnoses included, but were not limited to, diabetes, hypertension, glaucoma, osteoporosis, and sleep apnea. During a review of the recapitulation of physician's orders for April 2014, Resident #106 had a physician's order, "7/24/12: Accucheck's check blood sugar twice daily [once in the morning and once in the afternoon], call MD [medical doctor] if <50 or >400 [less than 50 or greater than 400]," and "7/16/2012: Novolog Flexpen inject sub q [subcutaneous/beneath the skin] use per sliding scale, 201-250=2U [two units], 251-300=4U [four units], 301-350=6U [six units], 351-400=8U [eight units]." During a review of the "Blood Glucose Monitoring Record" for Resident #106 for April 2014, Resident #106 lacked blood glucose results for the afternoon on 4/6/14, 4/8/14, 4/24/14, and 4/29/14 and lacked morning blood glucose results for 4/10/14 and 4/20/14. On 4/9/14, Resident #106 had a documented blood glucose of "46" and on 4/22/14 had a documented blood glucose of "36." The nurse's notes for Resident #106 were reviewed from 1/12/14 through 4/24/14, and lacked documentation of physician notification of the blood sugar result of 46 and the blood sugar of 36.		will be completed to ensure residents have current weights, diagnoses and diet orders and that all labs have been completed as physician ordered. An additional audit will be completed of those residents who receive blood glucose monitoring to ensure that physician notification of blood sugar results as well as sliding scale insulin administration is completed per physician order. Any deficiencies identified during these audits will be immediately corrected. 3. Current diet orders and diagnoses will be obtained by nursing staff and documented in the clinical record for residents upon admission and as indicated thereafter. Weights will be obtained by nursing staff and documented in the clinical record for residents upon admission and at least semi-annually thereafter. A new admission chart audit will be completed by nursing staff to ensure that diet orders, diagnoses and weights have been obtained per facility policy. In addition, a tracking system will be put in place to ensure that weights are obtained semi-annually thereafter. Residents	

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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
	A review of the medication administration record (MAR) for Resident #106 for April 2014 lacked documentation of sliding scale insulin administration for 4/7, 4/10, 4/13, 4/14, 4/16, 4/17, and 4/25/14. On 4/4/14 Resident #106 was documented as having a blood glucose of 338. Documentation on the MAR indicated Resident #106 received "zero" units of sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 6 units of insulin. On 4/5/14 Resident #106 was documented as having a blood glucose of 213. Documentation on the MAR indicated Resident #106 received "zero" units of sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 2 units of insulin. On 4/7/14 Resident #106 was documented as having a blood glucose of 277. Documentation on the MAR lacked documentation of Resident #106 receiving sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 4 units of insulin. On 4/14/14 Resident #106 was documented as having a blood glucose of 287. Documentation on the MAR lacked documentation of Resident #106 receiving sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 4 units of insulin. On 4/16/14		receiving blood glucose monitoring will have results and any subsequent physician notification as ordered documented on the Blood Glucose Monitoring Form by nurses and QMA's to be maintained the clinical record. The Blood Glucose Monitoring Form has been revised to include physician ordered notification parameters as well as documentation of physician notification. Residents receiving sliding scale insulin administration by nurses will have documentation of such on the medication administration record. Residents with physician ordered labs will be tracked by nursing staff to ensure that labs are completed as ordered and results are maintained on the clinical record. Training will be conducted by the DON and Regional Director of Clinical Services for all nurses and QMA's on facility policies and procedures for new resident admission requirements; resident weight	

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	Resident #106 was documented as having a blood glucose of 239. Documentation on the MAR lacked documentation of Resident #106 receiving sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 2 units of insulin. On 4/18/14 Resident #106 was documented as having a blood glucose of 219. Documentation on the MAR lacked documentation of Resident #106 receiving sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 2 units of insulin. On 4/22/14 Resident #106 was documented as having a blood glucose of 246. Documentation on the MAR indicated Resident #106 received "zero" units of sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 2 units of insulin. On 4/23/14 Resident #106 was documented as having a blood glucose of 241. Documentation on the MAR indicated Resident #106 received "zero" units of sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 2 units of insulin. On 4/25/14 Resident #106 was documented as having a blood glucose of 341. Documentation on the MAR lacked documentation of Resident #106 receiving sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have		monitoring requirements; blood glucose monitoring and sliding scale administration requirements and lab monitoring requirements during the week of June 2nd, 2014. 4. The DON and/or designee will conduct a series of ongoing audits of the clinical record to ensure the deficient practices do not recur. These audits will include a review of current physician orders; vital sign and weight monitoring records; blood glucose monitoring records; medication administration records and lab results. Audits will be completed weekly x4 weeks, monthly x2 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. 5. These systematic changes will be completed by 6/5/14	

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	received 6 units of insulin. On 4/26/14 Resident #106 was documented as having a blood glucose of 215. Documentation on the MAR indicated Resident #106 received "zero" units of sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 2 units of insulin. On 4/27/14 Resident #106 was documented as having a blood glucose of 262. Documentation on the MAR indicated Resident #106 received "zero" units of sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 4 units of insulin. On 4/28/14 Resident #106 was documented as having a blood glucose of 272. Documentation on the MAR indicated Resident #106 received "zero" units of sliding scale insulin. As indicated by the sliding scale insulin order, Resident #106 should have received 4 units of insulin. During an interview with the DoN on 5/1/14 at 3:35 p.m., the DoN indicated the call orders for glucose monitoring for Resident #106 had to have been a typographical error, and any physician's notifications of decreased glucose results should be documented in the nurse's notes. On 5/2/14 at 9:30 a.m., the DoN indicated facility had failed to completed blood glucose monitoring as ordered, and had failed to notify the physician of the			

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	decreased blood sugar on 4/9/14 and 4/22/14. The DoN indicated the lack of documentation of insulin administration meant the insulin was not given, "Not documented, then it was not done." 2a. The clinical record of Resident #127 was reviewed on 5/1/14 at 2:40 p.m. Diagnoses included, but were not limited to, edema and diabetes mellitus. A Vital Signs Record indicated Resident #127 had been weighed on 6/1/12 and 9/25/12. No other weights were found in the resident's record. During an interview with the Director of Nursing on 5/2/14 at 8:35 a.m., she indicated she could not find any other weights for Resident #127. 2b. The clinical record of Resident #90 was reviewed on 5/2/14 at 8:50 a.m. Diagnoses included, but were not limited to, depression and hypothyroidism. A Vital Signs Record indicated Resident #90 had been weighed on 1/18/13 and 3/31/14. No other weights were found in the resident's record. During an interview with the Director of Nursing on 5/2/14 at 3:40 p.m., she indicated she could not find any other			

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	weights for Resident #90. 2c. The clinical record of Resident #48 was reviewed on 5/1/14 at 1:10 p.m. No diagnoses were indicated in the resident's record. A Vital Signs Record indicated Resident #48 had been weighed in 1/2013 and 3/30/14. No other weights were found in the resident's record. During an interview with the Director of Nursing on 5/2/14 at 3:40 p.m., she indicated she could not find any other weights for Resident #48. 2d. Resident #47's clinical record was reviewed on 5/2/14 at 9:00 a.m. Diagnoses included but were not limited to, coronary artery disease (build up of a waxy substance in the vessels of the heart), congestive heart failure (condition where the heart cannot pump enough blood to the body), myocardial infarction (heart attack), and chronic renal disease (kidney failure). During the record review of Resident #47's chart no information regarding weights was found from 2/27/13 to 1/01/14. An interview dated 5/02/14 at 12:30 p.m.,			

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	the DoN indicated she was unable to locate any weights between February 2013 till January 2014. The policy of the facility was to perform weights on the Senior Living Residents at admission then quarterly, unless indicated to perform the weights more often, for example a physician order requesting weights daily. On 5/02/14 at 8:35 a.m., the DoN provided the Resident Weight Monitoring Policy, dated 12/15/2011, and indicated the policy was the one currently used by the facility. Review of the policy indicated, "Senior Living Resident Procedure: 1. Resident weight will be measured on admission, quarterly and as indicated thereafter... 5. Weights will be recorded on Vital Sign Record and maintained in chart." 3. The clinical record of Resident #48 was reviewed on 5/1/14 at 1:10 p.m. No diagnoses were indicated in the resident's record. During an interview with the DON on 5/1/13 at 3:20 p.m., she indicated she was unable to find any diagnoses for Resident #48 in her clinical record. 4. The clinical record of Resident #48 was reviewed on 5/1/14 at 1:10 p.m. No			

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	diet orders were found in the resident's physician orders. During an interview with the DON on 5/1/13 at 3:20 p.m., she indicated she was unable to find any diet orders in her clinical record.			
R000409	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents had an annual health statement (statement that the resident shows no evidence of tuberculosis in an infectious stage) upon admission and annually for 2 of 9 resident charts reviewed in that charts did not have an annual health statement. (Resident #18 and #27) Findings include: 1. Resident #18's clinical record was reviewed on 5/01/2014 at 12:00 p.m. Diagnoses included but were not limited to, anxiety, depression, and joint pain. Resident #18 was admitted on 4/07/2014. During the record review no information	R000409	1. Resident #18 and # 27 have current physician statements indicating they are free of communicable diseases including TB in an infectious state. 2. All residents have the potential to be affected by this alleged deficient practice. An audit of resident medical records will be completed to ensure residents have current annual health statements. Any deficiencies identified during this review will be immediately corrected.	06/05/2014

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	regarding an annual health statement on admission was found. An interview on 5/02/2014 at 9:15 a.m., the DoN indicated an annual health statement was not obtained prior to admission for Resident #18. The facility was waiting for the Medical Director's monthly visit to complete an annual health statement. Prior to admission the employees in charge of marketing and admissions request a history and physical from each resident. An interview on 5/05/2014 at 11:15 a.m., the Director of Community Relations indicated she is one of the employees that talks with residents prior to admission. She requests a chest X-ray from the past 6 months, a Tuberculosis (infectious disease) screen from the last 3 months, a current physical and a current medication list. If the resident has not had any of these screening tests in the specified time frame she helps them set it up. She indicated she has not been requesting an annual health statement from each resident, but will start to. 2. Resident #27's clinical record was reviewed on 5/01/2014 at 2:00 p.m. Diagnoses included but were not limited to, chronic obstructive pulmonary disease (poor air flow through the lungs),		3. Residents will have a health assessment completed prior to admission and documented on the Resident Physical Examination. In addition, the health assessment will be verified upon admission and annually thereafter as documented on the recapitulation of physician orders. Training will be conducted by the ED for the Marketing/Sales team as well as by the DON and Regional Director of Clinical Services for all nurses and QMA's on health assessment requirements upon admission and ongoing during the week of June 2nd, 2014. 4. The DON and/or designee will conduct an audit of resident medical records to ensure compliance with health assessment requirements monthly x3 months and quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further	

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	hypertension (high blood pressure), and diabetes (condition with high blood sugar). Resident #27 was admitted on 3/21/2011. During the record review no information regarding an annual health statement was found for 2013 or the first four months of 2014. An interview on 5/02/2014 at 11:35 a.m., the DoN indicated no annual health statement was found for Resident #27 since admission in 2011. The annual health statement had not carried over from the original orders in 2011. At the facility the annual health statement is normally located on the recapulated orders (monthly physician orders).		recommendations accordingly. 5. These systematic changes will be completed by 6/5/14	