

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/20/2022	
NAME OF PROVIDER OR SUPPLIER CHAPTERS LIVING OF GREENSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 1034 CROWN POINTE BLVD, GREENSBURG, , 47240					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: December 19 and 20, 2022 Facility number: 011914 Residential Census: 34 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 22, 2022.	R 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to				

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			confirm said compliance, feel free to contact me.	
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure nursing staff were	R 0117	R117 Requires the facility to ensure nursing staff is licensed. 1. LPN 3 immediately renewed her license. 2. All residents have the potential to be affected. The facility immediately conducted an audit to ensure all licensed staff had a valid license. No concerns were noted. See below for corrective measures. 3. The staff was educated on renewing staff license per state regulation. 4. The DON or her designee will review staff license monthly to ensure they are valid. The DON or her designee will utilize the nursing monitoring tool monthly times four weeks, then every other month	01/09/2023

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licensed for 1 of 13 nursing personnel files reviewed. (LPN 3)

Findings include:

The employee licensure records were provided by the DON (Director of Nursing) on 12/20/22. LPN (Licensed Practical Nurse) 3's nursing license expired on 10/31/22. The LPN's nursing license was reviewed on the Indiana Professional Licensing Agency website. The nursing license expired on 10/31/22 and a copy was provided by the BOM (Business Office Manager) on 12/20/22 at 10:54 A.M.

The Employee Time Card Report was provided by the BOM on 12/20/22 at 10:51 A.M. The report indicated LPN 3 worked in the facility providing care to residents without a valid nursing license on the following dates:

- 11/12/22,
- 11/13/22,
- 11/26/22,
- 11/27/22,
- 11/30/22, and
- 12/10/22.

During an interview on 12/20/22 at 10:23 A.M., the AIT

times four months, then every six months until 100% compliance is obtained and maintained. (See attachment A) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.

5.
The above corrective measures will be completed on or before January 9, 2023.

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(Administrator In Training) and the DON indicated LPN 3's license was expired. It was the nurse's job to ensure their license was active. The nurse should not have worked with an expired license.

Based on record review and interview, the facility failed to ensure nursing staff were licensed for 1 of 13 nursing personnel files reviewed. (LPN 3)

Findings include:

The employee licensure records were provided by the DON (Director of Nursing) on 12/20/22. LPN (Licensed Practical Nurse) 3's nursing license expired on 10/31/22. The LPN's nursing license was reviewed on the Indiana Professional Licensing Agency website. The nursing license expired on 10/31/22 and a copy was provided by the BOM (Business Office Manager) on 12/20/22 at 10:54 A.M.

The Employee Time Card Report was provided by the BOM on 12/20/22 at 10:51 A.M. The report indicated LPN 3 worked in the facility providing care to residents without a valid nursing license on the following dates:

- 11/12/22,

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	- 11/13/22, - 11/26/22, - 11/27/22, - 11/30/22, and - 12/10/22. During an interview on 12/20/22 at 10:23 A.M., the AIT (Administrator In Training) and the DON indicated LPN 3's license was expired. It was the nurse's job to ensure their license was active. The nurse should not have worked with an expired license.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to follow physician's orders to	R 0243	R243 Requires the facility to follow physician's orders to monitor a resident's blood pressure prior to medication administration. 1. Resident 2 blood pressure was obtained and no concerns noted. 2. All residents have the potential to be affected. The facility immediately conducted education with QMAs/nurses to ensure they were educated on the need to obtain a blood pressure prior to administering medication. No concerns were	01/09/2023

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FORM APPROVED

OMB NO. 0938-0391

monitor a resident's blood pressure prior to medication administration for 1 of 7 resident records reviewed. (Resident 2)

Findings include:

During an interview on 12/19/22 at 10:47 A.M., Resident 2 indicated the nurse put her medications in a weekly box and she took them daily.

The clinical record was reviewed on 12/20/22 at 9:55 A.M. An Admission Assessment, dated 02/04/22, indicated the resident was alert and oriented.

An original physician's order, that was signed by the ADON (Assistant Director of Nursing) and faxed to the pharmacy, dated 10/24/22, was provided by the ADON on 12/20/22 at 10:47 A.M. The order included, but was not limited to, the following:

- increase Torsemide (a diuretic / water pill) to 100 mg (milligrams) daily in the morning, hold for SBP (Systolic Blood Pressure) less than 100.

- increase Spironolactone (a diuretic) to 100 mg daily in the morning, hold for SBP less than 110.

The resident's MARs (Medication Administration Records) and "BLOOD

noted. See below for corrective measures.

3. The medication administration policy and procedure was reviewed with no changes made. (See attachment B) The staff was inserviced on the above procedure.

4. The DON or her designee with review the medication assessment record daily to ensure a blood pressure is obtained per the physician's order. The DON or her designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. (See attachment C) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly.

5. The above corrective measures will be completed on or before January 9, 2023.

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PRESSURE/VITALS READINGS" records for October, November, and December 2022, were provided by the ADON on 12/20/22 at 10:47 A.M. The records lacked documentation that the resident's blood pressure was checked prior to the resident receiving the prescribed diuretic medications.

During an interview on 12/20/22 at 10:20 A.M., the ADON indicated if a resident had an order for blood pressure checks, they would be under their name in the MAR. The MAR would be filed in their chart under medications. Resident 2's blood glucose was checked three times a day and her weight weekly. If the resident was to have her blood pressure checked it would have been on the "BLOOD PRESSURE/VITALS READINGS" record. The resident had hold parameters for her Torsemide, a blood pressure medication. The resident's blood pressure should have been documented on the "BLOOD PRESSURE/VITALS READINGS" record with her weights.

During an interview on 12/20/22 at 11:12 A.M., the DON (Director of Nursing) indicated it was a "best nursing practice" to obtain a blood pressure when administering cardiac and

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diuretic medications.

The current "MEDICATION ADMINISTRATION" policy, dated 06/2021, was provided by the DON on 12/20/22 at 11:18 A.M. The policy indicated, "...PURPOSE...To provide ordered medications and relative documentation of staff intervention ensuring proper daily medication administration..."

The current "PHYSICIAN ORDERS" policy, with a readopted date of 2022, was provided by the DON on 12/20/22 at 11:28 A.M. The policy indicated, "...Facility nursing personnel will ensure clear, accurate and complete physician's orders..."

Based on interview and record review, the facility failed to follow physician's orders to monitor a resident's blood pressure prior to medication administration for 1 of 7 resident records reviewed. (Resident 2)

Findings include:

During an interview on 12/19/22 at 10:47 A.M., Resident 2 indicated the nurse put her medications in a weekly box and she took them daily.

The clinical record was reviewed on 12/20/22 at 9:55 A.M. An Admission Assessment, dated 02/04/22,

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indicated the resident was alert and oriented.

An original physician's order, that was signed by the ADON (Assistant Director of Nursing) and faxed to the pharmacy, dated 10/24/22, was provided by the ADON on 12/20/22 at 10:47 A.M. The order included, but was not limited to, the following:

- increase Torsemide (a diuretic / water pill) to 100 mg (milligrams) daily in the morning, hold for SBP (Systolic Blood Pressure) less than 100.

- increase Spironolactone (a diuretic) to 100 mg daily in the morning, hold for SBP less than 110.

The resident's MARs (Medication Administration Records) and "BLOOD PRESSURE/VITALS READINGS" records for October, November, and December 2022, were provided by the ADON on 12/20/22 at 10:47 A.M. The records lacked documentation that the resident's blood pressure was checked prior to the resident receiving the prescribed diuretic medications.

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During an interview on 12/20/22 at 11:12 A.M., the DON (Director of Nursing) indicated it was a "best nursing practice" to obtain a blood pressure when administering cardiac and diuretic medications.

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)			
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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