STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	09/10/2015

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COUNTRY CHARM VILLAGE	7212 US HWY 31 S INDIANAPOLIS, IN 46227

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: September 8, 9, and 10, 2015. Facility number: 003283 Provider number: 003283 AIM number: N/A Census bed type: Residential: 57 Total: 57 Sample: 9 These State findings are cited in accordance with 410 IAC 16.2-5. QR was completed by 14466 on September 15, 2015.	R 0000	This plan of correction is submitted as required under either or both State and Federal Law. The submission of this plan of correction on 9/27/2015 does not constitute an admission of fault of liability to the government entity or any third party, or on the part of Country Charm Village, as to the accuracy of the surveyors' findings of the conclusions drawn therefrom. Submission of this plan of correction also does not constitute an admission that the findings constitute a noncompliance or deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes of the communitiies policies and procedures should be considered to be a subsequent remedial measures as that concept is employed in Rule 47 of the Federal Rules of Evidence and any corresponding state rule of civil procedure should be inadmissible in any proceeding on that basis and the community reserves the right to object to the admission of this statement of deficiency or the plan of correction under any other theory of Law. The community submits this plan of correction with the intention that it is inadmissible by any third party in any civil or criminal action against the community or any employee,	

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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			agent, officer, director, attorney, or shareholder of the community or affiliated companies.	
R 0095 Bldg. 00	410 IAC 16.2-5-1.3(l)(1-2) Administration and Management -Noncompliance (l) In facilities that are required under IC 12-10-5.5 to submit an Alzheimer's and dementia special care unit disclosure form, the facility must designate a director for the Alzheimer's and dementia special care unit. The director shall have an earned degree from an educational institution in a health care, mental health, or social service profession or be a licensed health facility administrator. The director shall have a minimum of one (1) year work experience with dementia or Alzheimer's residents, or both, within the past five (5) years. Persons serving as a director for an existing Alzheimer's and dementia special care unit at the time of adoption of this rule are exempt from the degree and experience requirements. The director shall have a minimum of twelve (12) hours of dementia-specific training within three (3) months of initial employment as the director of the Alzheimer's and dementia special care unit and six (6) hours annually thereafter to: (1) meet the needs or preferences, or both, of cognitively impaired residents; and (2) gain understanding of the current standards of care for residents with dementia. Based on record review and interview, the facility failed to submit a dementia special care unit disclosure form. Findings include:	R 0095	1. All residents residing in the Memory Care Unit were allegedly affected by this noncompliance and the corrective action to be accomplished is described below.2. To ensure all residents	09/11/2015

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	On 9/10/15 at 3:45 p.m., the facility's dementia special care unit disclosure form was requested from the Executive Director. At the time of survey exit, on 9/10/15 at 5:00 p.m., the disclosure form had not been provided. The Executive Director indicated she was not aware one had been submitted.		are no longer at risk to be affected by this noncompliance the Executive Director obtained the Alzheimer's/Dementia Special Care Unit Disclosure State Form 48896 and has completed this form to be mailed to the Division of Disability, Aging and Rehabilitative Services.3. The measure to be put into practice to ensure this noncompliance does not recur is the Executive Director will complete the Alzheimer's/Dementia Special Care Unit disclosure State Form 48896 annually.4. the Executive Director as well as the Regional Director shall monitor annual compliance of submission of the Alzheimer's/Dementia special Care Unit Disclosure Form.5. The date the systemic change will be completed by is September 11, 2015.	
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test			

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	must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on interview and record review, the facility failed to ensure health screens were completed for 2 of 10 employees reviewed for health screens (Employees #3 and #6) and tuberculin skin tests were completed for 5 of 10 employees reviewed for tuberculin skin tests (employees #2, #3, #4, #5, and #7). Findings include: 1. A review of employee records (file) was completed on 9/10/15 at 9:00 a.m.,	R 0121	1. All employees noted in this survey have had their health screens completed.2. The Business Office Director shall reveiw all current employee personnel files to determine any employee who is missing the required health screening and tuberculin skin test. The nursing department shall initiate any missing skin test, and record in the respective employee file.3. The current new hire policy requires the proper screening to include TB testing and physical health assessment screening. The Business Office Director	10/10/2015

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	for Employees #3 and #6. a. A review of Employee #3's file, lacked a health screen. b. A review of Employee #6's file, lacked a health screen. On 9/10/15 at 3:40 p.m., the Executive Director (ED) provided an undated Policy for Hiring Staff, and indicated the policy was the one currently used by the facility. The policy indicated, "...When hiring the following must be done PRIOR TO HIRE: ...4. A PHYSICAL NEEDS TO BE COMPLETED BY OUR MEDICAL DIRECTOR [health screen]...." On 9/10/15 at 4:10 p.m., documentation for health screens was requested for Employees #3 and #6 from the ED. No further information was provided by end of exit conference on 9/10/15 at 5:00 p.m. 2. A review of employee records (file) was completed on 9/10/15 at 9:00 a.m., for Employees #2, #3, #4, #5, and #7. a. A review of Employee #2's file, indicated Employee #2 received a tuberculin skin test on 9/9/14. No annual tuberculin skin test for 2015, was found		shall ultilize the new hire requirement checklist to monitor and record all new hire employee socuments. these documents will be placed in an enclosed envelope and placed in each employee file.4. The Director of Nursing shall be responsible for monitoring the completion of all new hire health screens including 1st and 2nd Step TB monitoring.5. The date of the systemic changes will be completed by October 10, 2015.	

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	in the file. b. A review of Employee #3's file, indicated Employee #3 received a 1st step tuberculin skin test on 8/4/14. No 2nd step tuberculin skin test was found in the file. c. A review of Employee #4's file, indicated Employee #4 received a 1st step tuberculin skin test on 7/29/15. No 2nd step tuberculin skin test was found in the file. d. A review of Employee #5's file, lacked a 1st step tuberculin skin test. e. A review of Employee #7's file, indicated Employee #7 received a tuberculin skin test on 2/9/14. No annual tuberculin skin test for 2015, was found in the file. On 9/10/15 at 3:40 p.m., the Executive Director (ED) provided an undated Mantoux Testing Policy, and indicted the policy was the one currently used by the facility. The policy indicated, "...All Employee Partners who do not have a documented history of a positive TB test must have a Mantoux method TB [tuberculin] test....Employee Partners must undergo TB testing within 14 days of hire (or as indicated by state			

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	regulations). The initial test should follow CDC [Center for Disease Control and Prevention] guidelines regarding one or two-step process....Annual testing may be one step..." On 9/10/15 at 4:10 p.m., documentation for tuberculin skin test was requested for Employees #2, #3, #4, #5, and #7 from the ED. No further information was provided by end of exit conference on 9/10/15 at 5:00 p.m.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure pro re nata (PRN) medications were administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician for 1 of 7 residents reviewed for PRN medication administration (Resident #74).	R 0246	1. The corrective action for resident #74 affected by the alleged deficiency will be accomplished by reassessing Resident 74's pain level and review of the residents' current medication to determine if the PRN medication should be a scheduled medication verses a PRN medication. The charge nurse will notify the resident's attending physician to make this	10/16/2015

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	Findings include: The clinical record for Resident #74 was reviewed on 9/9/15 at 9:30 a.m. Diagnoses included, but were not limited to, depression and hypertension. A review of the medication administration record (MAR) for July and August, 2015, indicated Resident #74 received a PRN medication administered by a QMA without authorized documentation from a licensed nurse in the resident record on 7/16, 7/18, 7/20, 7/21, 7/22, 7/23, 7/27, 7/28, 7/29, 7/30, 7/31, 8/3, 8/4, 8/5, 8/6, 8/7, 8/8, 8/10, 8/13, 8/14, 8/17, 8/19, 8/21, 8/24, 8/25, 8/26, and 8/27. During an interview on 9/9/15 at 2:10 p.m., the Executive Director (ED) indicated QMAs are to contact the licensed nurse prior to administering a PRN medication and the licensed nurse is to document information regarding the PRN medication on the back side of the medication administration record (MAR). On 9/9/15 at 4:20 p.m., the Executive Director (ED) provided an undated PRN Medication Policy & Procedure, and indicated the policy was the one currently used by the facility. The procedure		medication routine. The QMA was given a performance deficiency and is no longer an employee of this facility.2. To ensure all residents are not affected by this alleged deficient practice a review of all PRN medications will be completed at each resident service plan review.3. The Director of Nursing and Executive Director will inservice the QMA's and Licensed Nurse's regarding the facility PRN Medication Policy and Procedure. Each QMA are given their scope of practice rules at the time of hire and at various times throughout their employment. An acknowledgement of the above will be placed in the employee file and witnessed by the Executive Director.4. To ensure the alleged deficiency practice does not recur the Director of Nursing will monitor the PRN medication MARS on a daily basis for four weeks, then weekly thereafter. Any discrepancies found, the Licensed Nurse and QMA will be given a performance deficiency warning. Should there be no improvement in performance then the employee will be terminated.5. The systemic change will be completed by October 16, 2015.	

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	indicated, "...(11) Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift or, if the nurse was on call, by the end of the nurse's next tour of duty...."			
R 0306 Bldg. 00	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: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number.			

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	(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 the disposition of a discharged resident's medications were documented in the clinical record for 1 of 2 discharged residents reviewed for disposition of medications. (Resident #80) Findings include: The clinical record of Resident #80 was reviewed on 9/9/15 at 3:35 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus, coronary artery disease, high blood pressure, stroke, and depression. The resident discharged from the facility on 8/28/15. Recapitulated physician orders for August, 2015, with an original order date of 3/31/15, indicated the resident was to receive Lipitor (a cholesterol lowering medication) 20 milligrams (mg) daily, Plavix (a medication used to help prevent blood clots) 75 mg. daily, and lisinopril (a medication used to treat high blood	R 0306	1. The corrective action for this alleged noncompliance for resident # 80, who is responsible for himself, requested only the medications he thought he would need. Those were his Lisinopril, Plavix, and Insulin. The remaining medications have been pulled by the pharmacy tech and will be destroyed.2. The alleged noncompliance can affect all residents upon discharge and the corrective action will include instructions regarding the release, return, or destroy of medications at the time of discharge, including proper documentation in the resident's clinical record.3. To ensure the noncompliance does not recur placement of a Discharge Checklist will be placed in the front of each resident's clinical record. The charge nurse on the shift that discharges the resident is responsible for following the Discharge Checklist.4. The Director of Nursing will audit all discharge clinical records for compliance.5. The systemic change will be completed by October 16, 2015.	10/16/2015

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	pressure) 10 mg daily. The August, 2015, recapitulated orders indicated the resident also was to receive Cymbalta (an anti-depressant medication) 60 mg daily, originally ordered 4/21/15. A nurse's note dated 8/28/15 at 4:00 p.m., indicated the resident "left the facility with friends and stated he would not be back...attempted to educate resident of medications, res[ident] refused." A "Late Entry" nurses's note, dated 8/28/15 at 4:00 p.m., indicated, "Medications were sent [with] resident [with] instructions to educate resident administration instructions. Meds [medications] given to resident." No documentation in the resident's record was found which indicated the name and strength of the medications, the prescription number, the number of medications, or the signature of the person receiving the medications. On 9/10/15 at 3:50 p.m., Licensed Practical Nurse #8 indicated she was not able to find any further documentation regarding the disposition of Resident #80's medications.			

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R 0349 Bldg. 00	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 were maintained in a complete and legible manner for 1 of 9 records reviewed. (Resident #17) Findings include: The clinical record of Resident #17 was reviewed on 9/8/15 at 12:40 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus and atrial fibrillation. Diabetes mellitus is a disease were the body does not produce enough natural insulin to remove sugar from the blood. Atrial fibrillation is an irregular, often rapid heart rate that cause the release of clots into the blood stream. a. A current physician's order with an original date of 5/25/15, indicated Resident #17 was to have a weekly	R 0349	1. The corrective action for the residents records identified in the alleged noncompliance accomplished is all finger stick documentation shall be placed on a Blood sugar Flow Sheet where spaces allows for legible documentation of Blood Sugar Results.2. This noncompliance may affect all residents who are described as a Diabetic. The Director of Nursing shall inservice all nursing staff regarding diabetic resident monitoring, including the use of the diabetic flow sheets, signing, and documenting the administering of the sliding scale insulin, date, times, and accurately recording of the capillary blood glucose readings.3. To ensure this noncompliance practice does not recur, the Director of Nursing shall review each resident's clinical record to determine documentation is legible in case there is a change in condition.4.	10/16/2015

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	PT/INR (a laboratory blood test) drawn. A PT/INR measures how quickly blood clots. The resident was receiving warfarin, a blood thinning medication; the amount of warfarin received depended on the results of the weekly PT/INR. A PT/INR was drawn weekly from 5/8/15 through 7/24/15. No PT/INR results were found in Resident #17's record between 7/25/15 and 8/24/15. A nurse's note indicated the resident had refused to have her lab drawn 8/21/15. On 9/10/15 at 11:05 a.m., Licensed Practical Nurse #8 indicated the resident had refused other times to have her blood drawn, but the refusals did not get documented. b. Recapitulated physician's orders for August, 2015, with an original order date of 6/12/15, indicated Resident #17 was to receive finger stick blood sugar tests 4 times per day and receive sliding scale NovoLog insulin injections, depending on the results of the finger stick blood tests. The results of the finger stick and the amount of sliding scale insulin given were to be documented in an approximately 1/4 inch square on the Medication Administration Record (MAR).		The Director of Nursing shall monitor daily for four weeks, then weekly for four weeks, then monthly for three months. The Executive Director shall co-sign the monitoring form as an additional quality assurance.5. The corrective action shall be completed by October 16, 2015.	

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COUNTRY CHARM VILLAGE	7212 US HWY 31 S INDIANAPOLIS, IN 46227

(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 resident's finger stick results on the MAR for August, 2015, indicated the following: 8/7 at 4:30 p.m. and 7:30 p.m.: illegible 8/8 at 7:30 p.m.: illegible 8/9 at 7:30 p.m.: illegible 8/11 at 4:30 p.m. and 7:30 p.m.: illegible 8/16 at 7:30 p.m.: illegible 8/21 at 4:30 p.m.: illegible 8/24 at 11:30 a.m., 4:30 p.m. and 7:30 p.m.: illegible 8/25 at 4:30 p.m. and 7:30 p.m.: illegible 8/26 at 7:30 p.m.: illegible On 9/9/15 at 9:55 a.m., Pharmacist #9 indicated many of the finger stick blood sugar test results on the August MAR were unreadable and it was important to have clear documentation in case a resident started to have blood sugar problems and a physician wanted to know past results and insulin doses.			

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R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure two-step and annual tuberculin skin tests were administered to residents for 6 of 9 residents reviewed for receiving tuberculin skin tests. (Residents #16, #53, #24, #31, #17, and #80) Findings include: 1. The clinical record of Resident #16 was reviewed on 9/9/15 at 10:50 a.m. The resident was admitted to the facility on 5/24/2010.	R 0410	1. This corrective action for residents #16, #53, #24, #31, #17 & # 80 has been accomplished with completed TB screenings.2. This alleged noncompliance could affect all other residents and the Director of Nursing shall perform a resident audit to verify all residents are in compliance with their 1st and 2nd Step TB testing and Annual tuberculin test and initiate new test where needed.3. To ensure this does not recur, the Director of Nursing has re-implemented infection control policies and procedures to ensure controlled practices designed to provide a safe, sanitary, and	10/10/2015

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	The resident's record indicated an annual tuberculin (TB) skin test was administered on 3/12/12. No other TB skin tests were found in her record. 2. The clinical record of Resident #53 was reviewed on 9/9/15 at 1:30 p.m. The resident was admitted to the facility on 9/1/15. The 1st step of the two-step TB skin test was administered on 8/14/15. Administration of a 2nd step TB test was not found in her record. 3. The clinical record of Resident #24 was reviewed on 9/8/15 at 3:00 p.m. The resident was admitted to the facility on 10/6/14. No information was found in the resident's record which indicated any TB skin tests had been administered. 4. The clinical record of Resident #31 was reviewed on 9/9/15 at 10:10 a.m. The resident was admitted to the facility on 8/13/15. The 1st step of the two-step TB skin test was administered in the physician's office on 8/14/15. No information was found in the resident's record which indicated the 2nd step had been administered.		comfortable environment intended to help prevent the development and transmission of disease and infection. The Director of Nursing shall inservice nursing staff regarding the resident admission assessment which includes the tuberculin skin test performance upon admission, and annual thereafter. The Director of Nursing shall create and maintain a resident tuberculin test listing via Vigilan which will also identify annual renewals monthly.4. The Executive Director will audit monthly Move-In's to ensure the corrective action is occurring.5. The date this corrective action shall be completed by is October 10, 2015.	

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	5. The clinical record of Resident #17 was reviewed on 9/8/15 at 12:40 p.m. The resident was admitted to the facility on 5/7/15. No information was found in the resident's record which indicated any TB skin tests had been administered. 6. The clinical record of Resident #80 was reviewed on 9/9/15 at 3:35 p.m. The resident was admitted to the facility on 3/31/15. No information was found in the resident's record which indicated any TB skin tests had been administered. On 9/10/15 at 10:35 a.m. Licensed Practical Nurse #8 indicated she was not able to find any of the above TB skin tests had been administered to Residents #16, #53, #24, #31, #17, and #80. On 9/10/15 at 3:40 p.m. the Executive Director provided an undated policy titled, "Guidelines When Conducting TB Testing on Residents," and indicated it was the policy currently used by the facility. The policy indicated, "All Residents must have a Mantoux method TB test within 14 days of their move-in date to the Community..."			

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	On 9/10/15 at 10:51 a.m. the Executive Director indicated it was the policy of the facility to administer two-step tuberculin skin tests to newly admitted residents and to administer them annually, thereafter.			