| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 11/09/2017 |

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| WELLINGTON AT SOUTHPORT THE | 7212 US HWY 31 S<br>INDIANAPOLIS, IN 46227 |

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| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Survey dates: November 6, 7. 8 & 9, 2017<br><br>Facility number: 003283<br><br>Residential Census: 62<br><br>Sample: 9<br><br>These State Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality Review completed on November 15, 2017. | R 0000 | **"This plan of correction is submitted as required under Stateand Federal law. The submission ofthis Plan ofCorrection does not constitute an admission on the part ofTheWellington atSouthport astothe accuracy ofthe surveyors' findings or theconclusions drawn therefrom.Submission ofthis Plan ofCorrection also does not constitute an admission thatthe findings constitute a deficiency or thatthe scope and severity regarding the deficiency cited are correctly applied. Any changes tothe Community's policies and procedures should be considered subsequent remedial measures as thatconcept is employed in Rule 407 ofthe Federal Rules of Evidence and any corresponding staterules ofcivil procedure and should be inadmissible in any proceeding on thatbasis. The Community submits this plan ofcorrection with the intention thatit be inadmissible by any third party in any civil or criminal action against theCommunity or any employee, agent, officer,director, attorney, or** | |

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

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| | | | **shareholder ofthe Community or affiliated companies."** | |
| R 0095<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(l)(1-2)<br>Administration and Management<br>-Noncompliance<br>(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:<br>(1) meet the needs or preferences, or both, of cognitively impaired residents; and<br>(2) gain understanding of the current standards of care for residents with dementia.<br>Based on record review and interview, the facility failed to ensure the Director of the Memory Care Unit had earned a degree from an educational institution for 14 of 14 residents residing on the | R 0095 | 1. All residents in the Memory Care Unit were allegedly affected by this non- compliance and the corrective action tobe accomplished isdescribed below. | 12/09/2017 |

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| | Memory Care Unit in a total of 62 residents who reside at the nursing facility.<br><br>Findings include:<br><br>In an interview on 11/7/17 at 2:30 p.m., the Executive Director (ED) indicated the Director of Nursing (DON), a Licensed Practical Nurse (LPN), was the Director of the Memory Care Unit, and had held this position since, "sometime in July," (2017) not sure of the exact date.<br><br>In an interview on 11/8/7 at 9:40 a.m., with the ED and DON, they indicated the DON was licensed as an LPN, but had not earned a degree in health care, mental health, or social service from an educational institution, and was not a licensed health facility administrator. | | 2. Toensure all residents are no longer affectedby this non -compliance, theExecutive Director, a licensed Comprehensive Health Facility Administrator, shall serve as the director over the Memory Care Unit.<br><br>3. The measure tobe put into practice toensure this non -compliance does not recur is the current Memory Care Unit Activity Director holds an Associate Degree in General Studies and shall complete the classes toobtain an Associate Degree in a Health Care profession and has already completed the 12 hours of Dementia specific training and will have one year experience with Dementia/Alzheimer's residents in January 2018.<br><br>4. The Executive Director shall monitor annual compliance.<br><br>5. The date the systematic changes will be completed by December 9,2017. | |
| R 0117<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(b)<br>Personnel - Deficiency<br>(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, | | | |

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| | 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.<br><br>Based on record review and interview, the facility failed to ensure 1 awake staff person with current cardiopulmonary resuscitation (CPR) and first aid certificate was on site at all times for 6 of 48 shifts reviewed from 10/23/17 to 11/7/17 for 62 of 62 residents who reside at the nursing facility.<br><br>Findings include:<br><br>A review of daily staffing sheets (which indicated staff, as worked schedule) dated 10/23/17 - 11/7/17 indicated the following:<br><br>10/23/17: 3rd shift - No first aid | R 0117 | 1.All employees noted in this survey have received their first aide certification.<br>2.The Business Office Manager shall review all current employee personnel files to determine any employee who is missing the required firstaide training. The DON shall initiate all training and record such CPR and First Aide training in the employee file and place the certification oftraining in the license/ certification binder.<br>3.The measure to be put into place to ensure that the deficiency does not recur is the DON will not schedule any shift without 1 awake staff person with current CPR and First Aide certification on site at all times. | 11/09/2017 |

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| | coverage<br><br>10/24/17: 3rd shift - No first aid coverage<br><br>10/30/17: 3rd shift - No first aid coverage<br><br>10/31/17: 3rd shift - No first aid coverage<br><br>11/6/17: 3rd shift - No first aid coverage<br><br>11/7/17: 3rd shift - No first aid coverage<br><br>Interview on 11/8/17 at 2:30 p.m., the ED and DON indicated that the above shifts were without first aid coverage. | | 1.The Executive Director will monitor compliance monthly.<br>2. The date the systemic change will be completed November 9, 2017 | |
| R 0296<br><br>Bldg. 00 | 410 IAC 16.2-5-6(b)<br>Pharmaceutical Services - Noncompliance<br>(b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff.<br>Based on observation, record review, and interview, the facility failed to ensure staff was competent when administering insulin as indicated by the insulin manufacturer's instructions and facility policy, for 2 of 2 observations. (Resident 72) | R 0296 | 1.The corrective action for the alleged non- compliance for resident 72 is all licensed nurses have been re-educated regarding the administration of the insulin Toujeo.<br>2.To ensure all residents who receive insulin medication assistance a review of insulin medications will be completed | 12/09/2017 |

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| | Findings include:<br><br>The clinical record of Resident 72 was reviewed on 11/8/17 at 10:35 a.m. Diagnoses for the resident included, but were not limited to diabetes mellitus and depression Diabetes is a disease caused by the body's inability to produce enough insulin, causing elevated blood sugar levels.<br><br>Manufacturer's instructions for using the Toujeo insulin pen, received from the Director of Nursing on 11/7/17 at 10:25 a.m., dated September, 2015, indicated: "Always do a safety test before each injection...to make sure that you get the correct insulin dose...Select 3 units...Press the injection button all the way in When insulin comes out of the needle tip, your pen is working correctly...Push the needle into skin... Place thumb on the injection button. Then press all the way in and hold...Keep the injection button held in and when you see '0' in the dose window, slowly count to 5. This will make sure you get your full dose After holding and slowly counting to 5, release the injection button. Then remove the needle from skin..."<br><br>Observation 11/7/17 10:00 a.m. Licensed Practical Nurse (LPN) 1 dialed | | body the DON.<br>3.To ensure the alleged non-compliance does not recur the instructions for the specific Toujeo insulin will be posted in the front of the resident MAR.<br>4.The DON will monitor the administration of residents receiving specific insulin's daily for four weeks, weekly for one monthly and thereafter monthly. The Executive Director will monitor compliance.<br>5. The date of the systemic change will be completed by December 9,2017. | |

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| | up 10 units of insulin for Resident 72, injected it subcutaneously, held the button with the needle in the skin for approximately 1 second ( instead of 5 seconds according to manufacturers's instruction), and then withdrew the needle.<br><br>Interview on 11/7/17 at 10:30 a.m. the Director of Nursing indicated she would provide inservice education to all the nurses.<br><br>Observation on 11/8/17 at 10:05 a.m., LPN 1 primed Resident 72's insulin pen with only 2 units of insulin, instead of 3 per manufacturer's instructions.<br><br>On 11/9/17 at 9:30 a.m. the Executive Director provided an undated policy, titled, "Toujeo Solostar Pens Priming," and indicated it was the policy currently used by the facility. The policy indicated, "Always perform the safety test before any injection from the pen to ensure proper pen function: Select a dose of 3 units...Press the injection button all the way in. You should see insulin at the tip of the needle...For administration using the Toujeo Solostar Pen, keep the injection button held in ad when you see '0' in the dose window, slowly count to 5 before withdrawing the needle from the skin to ensure that the full dose is | | | |

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| | delivered." | | | |
| R 0306<br><br>Bldg. 00 | 410 IAC 16.2-5-6(g)(1-9)<br>Pharmaceutical Services - Noncompliance<br>(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:<br>(1) The name of the resident.<br>(2) The name and strength of the drug.<br>(3) The prescription number.<br>(4) The reason for disposal.<br>(5) The amount disposed of.<br>(6) The method of disposition.<br>(7) The date of the disposal.<br>(8) The signature of the person conducting the disposal of the drug.<br>(9) The signature of a witness, if any, to the disposal of the drug.<br>Based on record review and interview, the facility failed to ensure disposition of controlled medications was performed as indicated by facility policy for 1 of 2 residents reviewed for disposition of medications. (Residents 76)<br><br>Findings include:<br><br>The closed clinical record of Resident 76 was reviewed on 11/7/17 at 11:10 a.m. Diagnoses for the resident included but | R 0306 | 1. Thecorrective action forthis alleged non- compliance is thecurrent Disposal and Destruction Policy and Procedures reflect thatcontrolled substances may be destroyed by two licensed nurses and /ora licensed nurse and the DON.<br>2. To ensure all residents are not affected by the alleged non-compliance a review of All Drug Destruction Forms will be audited for two signatures per the current policy by the DON.<br>3. To ensure the alleged non | 12/09/2017 |

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| | were not limited to, dementia and anxiety.<br><br>A recapitulated physician's order for August, 2017, with an original order date of 7/21/17, indicated Resident 76 was to receive Xanax, 0.25 mg (milligrams) once a day, and also once a day, as needed. Xanax is a medication given for anxiety and is considered a controlled substance (a category of drugs whose possession and use are restricted by law).<br><br>The resident was discharged from the facility on 8/31/17. A Drug Disposition Form, dated 9/1/17, indicated 34 Xanax, 0.25 mg, were destroyed due to the resident being discharged. The form was signed by Licensed Practical Nurse (LPN) 1 and LPN 2.<br><br>On 11/8/17 at 9:20 a.m. the Executive Director provided a policy, dated 2/25/15, titled Drug Disposal and Destruction Policy and Procedure, and indicated it was the policy currently used by the facility. The policy indicated controlled substances may be destroyed "By a consulting pharmacists and the Wellness Director as per state guidelines" or "Wellness Director and a witness...The Drug Disposal form..will also be completed for destruction and appropriate signatures of all parties involved in the | | -compliance does not recur<br>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 the following discharge checklist. The DON will audit the drug disposition forms on a weekly basis for the appropriate two licensed signatures.<br>4. The Executive Director will monitor compliance during daily department meetings.<br>5. The systemic changes will be completed by December 9, 2017. | |

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| | destruction..."<br><br>On 11/9/17 at 10:15 a.m., the Director of Nursing [Wellness Director] indicated she had not signed Resident 76's 9/1/17 Drug Disposition Form. | | | |
| R 0383<br><br>Bldg. 00 | 410 IAC 16.2-5-11.1(g)(1-2)<br>Mental Health Screening - Deficiency<br>(g) The residential care facility, in cooperation with the mental health service providers, shall develop the comprehensive careplan for the resident that includes the following:<br>(1) Psychosocial rehabilitation services that are to be provided within the community.<br>(2) A comprehensive range of activities to meet multiple levels of need, including the following:<br>(A) Recreational and socialization activities.<br>(B) Social skills.<br>(C) Training, occupational, and work programs.<br>(D) Opportunities for progression into less restrictive and more independent living arrangements.<br><br>Based on record review and interview, the facility failed to ensure a comprehensive careplan was developed wit resident specific interventions in cooperation with a mental health service provider for 1 of 1 resident reviewed with a diagnosis of a major mental illness. (Resident 28) | R 0383 | 1. The corrective action for the alleged deficiency for resident 28, who has and receives mental health services through Great Lakes Geri-psychological Health Services. Areas of resident 28's individualized service plan does reflect the psychologists recommendations however to ensure going forward the individualized service plan shall | 12/09/2017 |

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| | Findings included:<br><br>The clinical record of resident 28 was reviewed on 11/8/17 at 2:20 p.m. Diagnosis for the resident included, but were not limited to, schizophrenia, history of alcohol abuse and dementia.<br><br>A Psychotherapy Progress Note, dated 10/6/17, indicated resident was being seen for schizophrenia and anxiety. Residents mood and affect were blunted and resident was guarded of thoughts and emotions. Resident endorsed feelings of anxiety and loneliness.<br><br>A service plan for the resident, dated 10/10/17, indicated the following:<br><br>Mental Status: Orientation not determined or disoriented occasionally - No task description or instructions provided.<br><br>Medication: Takes 3 to 4 of these medications currently and/or within the past 7 day (narcotics, sedatives, seizure medication, blood pressure, psychotropic's, anti-depressants, dementia med's) - no task description or instructions provided.<br><br>Pre-disposing conditions: 1 to 2 present | | have a typed and/ or written explanation to the task description or instructions provided to the areas cited in this alleged deficiency.<br><br>2. To ensure all residents having the potential to be affected by the alleged deficiency, the DON shall review each resident who receives mental health services individualized service plan and either type and/ or hand write the interventions to the areas cited in 5is alleged deficiency.<br><br>3. To ensure the alleged deficiency does not recur the DON shall review with the mental health provider the residents individualized service plans and request interventions appropriate for the areas of this alleged deficiency on a semi -annual basis and/ or with a changed in condition.<br><br>4. The Executive Director shall review and monitor compliance as individual service plans are completed.<br><br>5. The date the systemic changes will be completed December 9, 2017. | |

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| | (arthritis, diabetes, Parkinson's dementia, stroke, TIA's, gait or balance disorders, glaucoma, restless leg syndrome, dizziness) - no task description or instructions.<br><br>Elope risk: Wanders through facility, but does not leave interior setting - no task descriptions or instructions provided.<br><br>Mental Health (Thought and Mood Problems): description of general mood behavior - anxious marked for expected result, no task description or instructions provided.<br><br>Mental Health (Thought and Mood Problems): history of hallucination and/or confusion - no task description or instructions provided.<br><br>State Indicator Matrix: psychoactive medications - no task description or instructions provided.<br><br>The service plan did not include any resident specific interventions for any of the areas shown above.<br><br>Interview on 11/8/17 at 2:35 p.m., the DON clarified interventions would be listed under the task description and instructions areas in the service plan. | | | |

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