

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2018
NAME OF PROVIDER OR SUPPLIER JOURNEY SENIOR LIVING OF VALPARAISO		STREET ADDRESS, CITY, STATE, ZIP COD 74 E JOURNEY WAY VALPARAISO, IN 46383		
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00275011.</p> <p>Complaint IN00275011 - Substantiated. State Residential Finding related to the allegations is cited at R0029, R0117, R0240, R0241, R0349.</p> <p>Survey date: December 10 & 11, 2018</p> <p>Facility number: 014081</p> <p>Residential Census: 24</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on 12/18/18.</p>	R 0000	<p>Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>The facility is also requesting a desk review for compliance in these areas.</p>	
R 0029 Bldg. 00	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency</p> <p>(d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.</p> <p>Based on observation and interview, the facility failed to ensure residents were treated with consideration and respect, related to staff talking about residents in front of residents and family members during a noon meal. This had the potential to affect 12 residents who reside on the Memory Care Unit.</p> <p>Finding includes:</p> <p>The noon meal in the Memory Care Unit was observed on 12/11/18 from 11:39 p.m. through 12:58 p.m. There were 12 residents and 3 family members in the Dining room until 12:08, when 1</p>	R 0029	<p>R0029 What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Facility reviewed all employee files to ensure acknowledgement of Resident Bill of Rights and HIPAA confidentiality (located in the Employee Handbook). LPN2 and Life Enrichment employees were given a documented verbal counseling notice in regards to</p>	12/27/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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	<p>resident and 2 family members left the dining room.</p> <p>At 12:08 p.m. Resident R indicated Resident Q's brownie looked really good. Life Enrichment informed Resident R that Resident Q received a diabetic brownie. She then walked over to Resident E, who was not holding the spoon correctly and called her honey as she was helping reposition the spoon.</p> <p>At 12:16 p.m., Life Enrichment walked behind Resident E, and indicated she was going to say Resident E ate well, then she stated, "but she is wearing it". LPN 2, who was sitting at the table assisting Resident B with her meal, looked at Resident E and stated, "you are supposed to eat it not wear it".</p> <p>At 12:47 p.m., LPN 2 called CNA 2 down to the Dining Room. When CNA 2 entered, LPN 2 stated, "the natives are getting restless", and the staff started assisting the residents out of the Dining Room.</p> <p>During an interview on 12/11/19 at 2:37 p.m., the Executive Director and Director of Nursing indicated the staff should not have been talking about others in front of the residents.</p> <p>This Residential tag relates to Complaint IN00275011.</p>		<p>their comments.</p> <p>How will you identify other residents having potential to be affected by the same deficient practice? Any resident has the potential to be affected by the same alleged deficient practice.</p> <p>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? All staff re-educated as to the Indiana State regulation R029 410 IAC 16.2-5-1.2, Resident Rights. All staff re-educated on HIPAA and what entails a violation of HIPAA. All staff educated on best practices for maintaining a resident's dignity. Resident Council held on 12/20 allowing any resident concerns to be heard. No issues on dignity or respect were voiced.</p> <p>How will the corrective action (s) be monitored to ensure the deficient practice will not recur? Executive Director and/or Designee will review all staff files upon hire to ensure Resident's Bill of Rights and HIPAA confidentiality (located in the employee handbook) have been acknowledged and completed. The Executive Director and/or</p>	

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R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (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	R 0117	designee will bring the results of audits to the monthly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Executive Director and results brought to next meeting. This will continue for 6 months. Monitoring will be ongoing.	12/27/2018

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	<p>failed to ensure a QMA (Qualified Medication Aide) completed only those duties for which they were trained to do, related to the QMA writing Physician's Orders and orders on a written prescription for medication, which was signed by the Nurse Practitioner, for 1 of 2 QMA's who had worked at the facility. (QMA 1 and Resident E)</p> <p>Finding includes:</p> <p>Resident E's record was reviewed on 12/11/18 at 9:44 a.m. The diagnoses included, but were not limited to, dementia.</p> <p>A Physician's Telephone Order, dated 9/29/18, indicated a new order for a nutritional shake twice a day. The signature line of "Nurse receiving the order" was signed by QMA 1.</p> <p>A Nurse's Progress Note, dated 9/27/18 at 9:25 p.m., indicated the order for Xanax (anti-anxiety) had been changed from 0.25 mg (milligrams) three times a day to 0.50 mg three times a day for 30 days. The note was signed by QMA 1.</p> <p>The prescription, dated 9/27/18, was signed by the Nurse Practitioner and indicated alprazolam (Xanax) 0.5 mg, one tab three times a day. Underneath the the prescription, QMA 1 wrote, "DC alprazolam 0.25 mg, one tablet three times a day."</p> <p>During an interview on 12/11/18 at 10:15 a.m., the Director of Nursing indicated QMA 1 should not have written and signed the Physician's Orders and the prescription should not have been altered.</p> <p>A QMA Job Description, received from the Director of Nursing on 12/11/18 at 4:41 p.m., indicated the QMA provided direct and indirect</p>		<p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>QMA 1 was terminated on 11/19/18 due to finding out she was not following State regulations, a reportable was sent to State on this matter on 11/19/18. On 12/12/18, QMA job description was revised to limit the amount of charting a QMA can do to ensure they stay within their scope of practice.</p> <p>How will you identify other residents having potential to be affected by the same deficient practice?</p> <p>Any resident has the potential to be affected by the same alleged deficient practice.</p> <p>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?</p> <p>Staff educated on the revised QMA job description which shows the new limitations as to what a QMA can do. Job descriptions are reviewed upon orientation and employees sign an acknowledgment form.</p> <p>How will the corrective action (s) be monitored to ensure the</p>	

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R 0240 Bldg. 00	<p>resident care activities under the direction of a RN or LPN, assisted residents with activities of daily living, provided for personal care, comfort and assisted in maintenance of a safe and clean environment. The responsibilities also included pouring, passing and documenting all routine prescribed medications and as needed medications upon the instructions of a Licensed Nurse and Physician.</p> <p>This Residential tag relates to Complaint IN00275011.</p> <p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility failed to ensure a resident who required assistance with toileting was assisted to the bathroom in a timely manner for 1 of 4 residents reviewed for Activities of Daily Living (ADL's). (Resident Q)</p> <p>Finding includes:</p> <p>During an observation on 12/11/18 at 12:15 p.m., Resident Q, CNA 1, LPN 2, and Life Enrichment were in the dining room when Resident Q indicated she needed to use the bathroom.</p>	R 0240	<p>deficient practice will not recur?</p> <p>Director of Nursing and/or designee will audit all resident's charts weekly. This audit is to ensure that facility staffed QMA's have followed all aspects of facility job description and scope of practice. The Director of Nursing and/or designee will bring the results of audits to the monthly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to next meeting. This will continue for 6 months. Monitoring ongoing.</p> <p>R240</p> <p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>CNA 1, CNA 2, and LPN 2 were given a corrective notice in regards to not timely attending to Resident Q. Upon review of resident Q's care plan and current health issues, it is noted that Resident Q had a UTI with ATB ordered on 12/5/18. Resident Q was still</p>	12/27/2018

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	<p>During an observation on 12/11/18 at 12:41 p.m., the resident asked if someone could help her get to the bathroom. CNA 1 informed the resident as soon as another staff member came back to the area, she would assist her to the bathroom.</p> <p>During an observation on 12/11/18 at 12:47 p.m., LPN 2, CNA 2, CNA 1, and the Director of Nursing was in the dining room. No one had assisted Resident Q to the bathroom.</p> <p>At 12:49 p.m. , CNA 1 was cleaning up the serving kitchen, rinsing dishes off and preparing them for the dishwasher. Resident Q had not been assisted to the bathroom.</p> <p>At 12:58 p.m., Resident Q came back to the Dining Room and again asked to be assisted to the bathroom. CNA 1 then assisted the resident to the bathroom. CNA 1 indicated the resident was not incontinent.</p> <p>Resident Q's record was reviewed on 12/11/18 at 4:06 p.m. The diagnoses included, but were not limited to, dementia.</p> <p>A Resident Assessment Form, dated 8/25/18, indicated frequent bladder incontinence, one assistance for transfers, and scheduled for toileting every two hours and as needed.</p> <p>This Residential tag relates to Complaint IN00275011.</p>		<p>receiving ATB treatment on 12/11/18 at time of survey.</p> <p>How will you identify other residents having potential to be affected by the same deficient practice? Any resident has the potential to be affected by the same alleged deficient practice. Resident Q was assessed for any emotional distress. No findings. Director of Nursing documented and communicated with Physician.</p> <p>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? Staff re-educated on those residents who need assistance toileting and the importance of ensuing that resident's requests for assistance are answered timely.</p> <p>How will the corrective action (s) be monitored to ensure the deficient practice will not recur? Director of Nursing and/or Designee will audit all resident charts to note any change in condition alerted by family or observation. All care plans will be reviewed within a 3 month intervals and ensure any major care needs or changes noted are also inserviced to staff to ensure</p>	

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R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to follow Physician's Orders related to a	R 0241	awareness and proper care provided. The Director of Nursing and/or designee will bring the results of audits to the monthly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to next meeting. This will continue for 6 months. Monitoring ongoing. Director of Nursing will also periodically do resident checks to ensure incontinence care is being provided as resident needs require. The Director of Nursing and/or designee will bring the results of audits to the monthly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to next meeting. This will continue for 6 months	12/27/2018

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	<p>consult for Psychiatric Services for 1 of 13 residents reviewed for Physician's Orders. (Resident H)</p> <p>Finding includes:</p> <p>Resident H's record was reviewed on 12/11/18 at 11:05 a.m. Diagnoses included, but were not limited to, Alzheimer's disease.</p> <p>A Nurse's Progress Note, dated 9/3/18 at 9 p.m., indicated the resident was very combative with CNAs when they were giving the shower. The resident punched one of the CNAs in the face and grabbed her necklace, scratched the inside of the forearm of the other CNA, was swinging at staff and yelling.</p> <p>A Resident Assessment, dated 9/28/18, indicated behaviors of aggression/agitation with physical aggression and verbal aggression during care and could be resistant to care.</p> <p>A Physician's Order, dated 10/16/18, indicated a Psychiatric consult for an evaluation and treatment.</p> <p>The resident had not received a Psychiatric consult as ordered by the Physician.</p> <p>During an interview on 12/11/18 at 4:25 p.m., the Director of Nursing indicated the resident had not has the consult as ordered.</p> <p>This Residential tag relates to Complaint IN00275011.</p>		<p>be accomplished for those residents found to have been affected by the deficient practice? Resident H seen by Psychiatrist on 12/24/18.</p> <p>How will you identify other residents having potential to be affected by the same deficient practice? Any resident has the potential to be affected by the same alleged deficient practice.</p> <p>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur? Staff re-educated on following through with Physician orders, whether a medication, or an evaluation and treatment from an outside source, to ensure the service is done in a timely manner.</p> <p>How will the corrective action (s) be monitored to ensure the deficient practice will not recur? Director of Nursing and/or designee will audit resident's charts 3 times a week to ensure that any new order has been conducted/started in the acceptable time frame from order date. The Director of Nursing and/or designee will bring the</p>	

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R 0349 Bldg. 00	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance</p> <p>(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:</p> <ul style="list-style-type: none"> (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented related to family notification of laboratory results and medication changes not documented in the record, for 2 of 13 residents reviewed for clinical records. (Residents J and M)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Resident J's record was reviewed on 12/11/18 at 10:54 a.m. The diagnoses included, but were not limited to, dementia. <p>A Physician's order, dated 11/27/18, indicated the following laboratory tests were ordered: CBC (complete blood count), CMP (comprehensive metabolic profile), lipids, TSH (thyroid).</p>	R 0349	<p>results of audits to the monthly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to next meeting. This will continue for 6 months. Monitoring is ongoing.</p> <p>R349 What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Notifications to family/ responsible parties were transferred from the communication form into resident charts.</p> <p>How will you identify other residents having potential to be affected by the same deficient practice? Any resident has the potential to be affected by the same alleged</p>	12/27/2018

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	<p>A Nurse's Note, dated 11/30/18 at 6 a.m., indicated the laboratory test results were faxed to the Physician. There was no documentation to indicate the Responsible Party had been notified of the laboratory test results.</p> <p>2. Resident M's record was reviewed on 12/11/18 at 10:37 a.m. The diagnoses included, but were not limited to, dementia.</p> <p>The Physician's Orders, indicated:</p> <p>11/9/18 - Coumadin (blood thinner) 6 mg (milligram) on 11/10/18 and 11/11/18, then give Coumadin 5 mg starting 11/12/18. Recheck the PT/INR (blood clotting tests) on 11/15/18.</p> <p>11/12/18 - Hold Coumadin 5 mg for one day, then resume.</p> <p>11/15/18 - Hold Coumadin x 5 days (11/15/18 to 11/19/18) Recheck the INR on 11/19/18.</p> <p>11/20/18 - Coumadin 2 mg daily. PT/INR on 11/27/18.</p> <p>11/28/18 - Coumadin 6 mg daily on 11/28/18, 11/29/18, and 11/30/18 then Coumadin 5 mg daily on 12/1/18. Recheck PT/INR on 12/4/18.</p> <p>12/4/18 - Coumadin 6 mg on 12/4/18, 12/5/18, and 12/6/18 then on 12/7/18 start Coumadin 5 mg daily PT/INR on 12/11/18.</p> <p>The PT/INR laboratory test were completed on 11/12/18, 11/15/18, 11/28/18, and 12/4/18. The Physician had been notified of the results.</p> <p>There was no documentation to indicate the Responsible Party had been notified of the medication changes and the laboratory test results.</p> <p>During an interview on 12/11/18 at 2:37 p.m., the</p>		<p>deficient practice.</p> <p>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?</p> <p>Staff re-educated on ensuring that clinical records are complete and accurately documented. This includes notifying family/responsible parties of any medication changes, lab and/or test results.</p> <p>How will the corrective action (s) be monitored to ensure the deficient practice will not recur?</p> <p>Director of Nursing and/or designee will audit all resident charts to ensure family notification of labs ordered. The Director of Nursing and/or designee will bring the results of audits to the monthly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to next meeting. This will continue for 6 months. Monitoring ongoing.</p>	

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

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	<p>Director of Nursing (DON) indicated the 24 hour Nurses Communication Form (unofficial paper used for shift change) had documentation to indicate the Responsible Parties had been notified of the results of the laboratory tests and all medication changes. She indicated there was no documentation in the residents' clinical records of the notification.</p> <p>This Residential tag relates to Complaint IN00275011.</p>				