STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155775	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CUMBERLAND POINTE HEALTH CAMPUS	**1051 CUMBERLAND AVE WEST LAFAYETTE, IN 47906**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents call lights were within reach for 2 of 3 residents reviewed for call lights (Resident D and E). Findings include: 1. During an observation, on 8/25/2020 at 2:23 p.m., Resident D was lying on her bed which was in the lowered position. Her call light was on the floor close to her roommate's night stand. The call light was not within reach of the resident. During an interview, on 8/25/2020 at 2:25 p.m., LPN 3 indicated the resident's call light was not within reach. The resident was capable of pushing the button on the call light and at times would throw the call light. The record for Resident D was reviewed on 8/25/2020 at 3:45 p.m. [DIAGNOSES REDACTED]. A care plan, dated 3/21/16, indicated the resident was at risk for falling. The approaches included, but were not limited to, keep the resident's call light in reach at all times. 2. During an observation, on 8/25/2020 at 2:20 p.m., Resident E was sitting up in her Broda chair next to her bed and facing the television. Her call light was on the floor behind her, close to the bedside table and tangled with another cord on the floor. During an observation, on 8/25/2020 at 2:23 p.m., the resident was able to push the button on the call light. During an interview, on 8/25/2020 at 2:21 p.m., LPN 3 indicated the call light was not in reach, the clip on the call light was broken and he would need to get a new clip. The record for Resident E was reviewed on 8/26/2020 at 11:10 a.m. [DIAGNOSES REDACTED]. A care plan, dated 1/22/2020, indicated the resident was at risk for falling. The approaches included, but were not limited to, keep the resident's call light within reach. The facility had not provided a policy on accommodation of needs at the time of exit. This Federal tag relates to Complaint IN 371. 3.1-3(v)(1)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's prescribed medications were available and failed to clarify a doctor's order for pain medication for 1 of 3 resident's reviewed for medications (Resident B). Finding includes: The record for Resident B was reviewed on 8/24/2020 at 3:45 p.m. [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The MAR (medication administration record) indicated the resident did not receive the [MEDICATION NAME] on 7/24/2020, 7/25/2020 and 7/26/2020. The comments indicated the drug was not administered due to being unavailable on all three dates. A care plan, dated 5/20/18, indicated the resident had a [DIAGNOSES REDACTED]. The approaches included, but were not limited to, opioids as ordered, administer medications as ordered and notify the medical doctor as needed. A telehealth visit with the medical doctor, dated 7/27/2020 at 2:50 p.m., indicated the resident's current medications included, but were not limited to, [MEDICATION NAME] 5-325 mg one tablet nightly as needed for pain. The MAR, dated 7/28/2020, indicated [MEDICATION NAME] 5-325 mg one tablet at bedtime. During an interview, on 8/26/2020 at 3:09 p.m., the Executive Director (ED) indicated the resident's [MEDICATION NAME] was not available on 7/24/2020, 7/25/2020 and 7/26/2020 and should have been available. The facility staff had contacted the physician's office and left a message for the doctor on 7/24/2020 and did not receive a response. The nursing manager did not follow up with the physician until 7/27/2020 when the resident had already been 3 days without the medication. During an interview, on 8/26/2020 at 3:16 p.m., the Director of Nursing (DON) indicated the resident's telehealth visit on 7/27/2020 with written instructions for the [MEDICATION NAME] did not match the MAR. She thought the physician just made an error on the telehealth visit. The DON indicated the physician should have been called to clarify the [MEDICATION NAME] administration order and was not called. A current policy, titled Provider Notification Guideline, dated as reviewed on 5/23/18 and received on 8/26/2020 at 3:30 p.m., from the campus clinical support, indicated .To ensure the resident's physician or practitioner .is aware of .change in condition in a timely manner to evaluate condition for need of provision or appropriate interventions for care .The provider should be notified of .or an immediate need by phone as soon as results are known with a response received before the call is completed when possible .if unable to reach the primary provider, the campus Medical Director will be notified .During non-office hour times the nurse should notify the physician/provider by phone of .the need for physician/provider intervention .If the attending physician, or their practitioner does not respond to notification attempts the Medical Director and Director of Health Services should be notified for further instruction This Federal tag relates to Complaint IN 557. 3.1-37(a)

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