

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/16/2013
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Survey Dates: December 9, 10, 12, 13 and 16, 2013.</p> <p>Facility Number: 000775 Provider Number: 15G255 AIM Number: 100248960</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/20/13 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), and three additional clients (#5, #6 and #7), the facility's governing body failed to exercise general policy, budget</p>	W000104	<p>Corrective action: Maintenance request was submitted and repairs scheduled for completion by 1-15-2014 (Attachment A). How we will identify others: Program</p>	01/15/2014

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 that other safeguards 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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W000368	<p>and operating direction over the facility to ensure a bathroom was maintained in good repair.</p> <p>Findings include:</p> <p>Observations were conducted at the home of clients #1, #2, #3, #4, #5, #6, and #7 on the evening of 12/09/13 from 3:15 PM until 6:00 PM and on 12/10/13 from 7:00 AM until 3:30 PM. During the observations, the half bath in the bedroom hallway had tape across the door and a sign that indicated it was not to be entered/used.</p> <p>Interview with staff #1 on 12/10/13 at 8:00 AM, indicated the half bath in the facility could not be used because the floor under the toilet was in need of repair and unsafe. Staff #1 stated the bathroom had been out of order for "two weeks."</p> <p>9-3-1(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review and interview for 1 of 4 sampled clients,</p>	W000368	<p>Manager will review preventative maintenance checklists (Attachment B) to ensure that needed repairs have been completed. Measures to be put in place: Program Manager Preventative checklist (Attachment B) has been implemented to ensure timely repairs. Monitoring of Corrective Action: Program Manager will review Maintenance requests weekly with maintenance coordinators to ensure timely repairs are completed. Completion Date: 1-15-2014</p> <p>compliance with the physician's orders. Corrective action: Clinical Supervisor and staff have</p>	01/01/2014

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	<p>(#4), and 1 additional client (#7), the facility failed to ensure their medications were administered according to the physician's orders.</p> <p>Findings include:</p> <p>During observations at the facility on December 9, 2013 at 4:15 PM, staff #3 prompted client #4 to come to the medication area. As client #4 waited for his medication, staff #3 consulted the 12/13 MAR (Medication Administration Record) and stated client #4's 4:00 PM medication Neurontin (anticonvulsant) 100 milligrams/mg. for shingles had been "discontinued." Staff #3 was asked if the Neurontin had been tapered and discontinued or stopped without tapering. Staff #3 consulted with Home Manager #1 regarding the Neurontin. Staff #3 indicated the Neurontin was not to have been discontinued. Staff #3 administered 100 mg of Neurontin to client #4 at 4:40 PM.</p> <p>Review of client #4's 12/13 MAR (12/09/13 at 4:40 PM) indicated client #4's last dose (prior to 12/9/13) of 100 mg Neurontin had been administered at the 7:00 AM medication administration on 12/05/13.</p> <p>Review of client #4's record on 12/10/13</p>		<p>been inserviced on checking physician's orders, discontinuing a medication, and proper medication administration (Attachment C). Staff received a medication error (Attachment C). How we will identify others: Nursing Coordinators will review Client Medication Administration records to ensure that medications are documented properly and that any discontinued medications have been documented.</p> <p>Measures to be put in place: Nursing Coordinators will perform weekly home visits, including checking Medication Administration records to ensure medications are dispensed per physician orders. (Attachment D). Monitoring of Corrective Action: Nursing Program Manager will review weekly Nursing checklist and perform bi-annual checklist, including checking Medication Administration records for correct administration of medications.. Completion Date: 1-1-2014</p>				

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	<p>at 12:23 PM indicated a physician's visit record dated 11/04/13. Client #4 had been diagnosed with Shingles and had been prescribed Neurontin 100 mg three times daily for nerve pain associated with the Shingles. There was no evidence the order for the Neurontin had been changed on 12/05/13. Review of the 12/13 MAR indicated client #4 had missed twelve doses of the Neurontin 100 mg.</p> <p>Interview with HM #1 on 12/09/13 at 4:45 PM indicated there was no discontinuation order for the Neurontin. HM #1 indicated the label on the medication blister package indicated no refills so the staff on duty 12/5/13 had mistakenly assumed the Neurontin was not to continue for client #4.</p> <p>Interview with staff #3 on 12/10/13 at 11:00 AM indicated the discontinuation of the Neurontin was investigated after the surveyor questioned it on 12/09/13 at 4:15 PM.</p> <p>Interview with HM #1 on 12/10/13 at 2:30 PM indicated the physician had been contacted and the Neurontin was not discontinued, but as of 12/10/13, it was to be tapered to 100 mg twice daily. The staff were to monitor client #4 for signs/symptoms of pain and contact the</p>						

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W000385	<p>physician if the Neurontin needed to be reinstated at three times daily.</p> <p>Review of reportable incidents on 12/12/13 at 1:56 PM indicated on 6/5/13 at 7:00 AM client #3's medication had been dispensed and left on the counter in the medication room while he went into the adjacent bathroom. Client #7 came into the medication room and took the medications in error. The medications client #7 took in error were Depakote 750 milligrams/mg (anticonvulsant), naproxen 500 mg, (pain reliever) Rapaflo 8 mg (benign prostatic hyperplasia), Risperdal 2 mg, (antipsychotic) thioridazine 50 mg (antipsychotic), Artane 5 mg (for medication side effects), Vitamin E 400 IU (international units) supplement, and Prilosec for reflux.</p> <p>9-3-6(a)</p> <p>483.460(l)(3) DRUG STORAGE AND RECORDKEEPING The facility must maintain records of the receipt and disposition of all controlled drugs. Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure the disposition of the client's controlled drug was documented correctly.</p>	W000385	W385: The facility must maintain records of the receipt and disposition of all controlled drugs..Corrective action:- Clinical Supervisor and staff have been inserviced on correctly	01/18/2014

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	<p>Findings include:</p> <p>During observations at the facility on 12/10/13 at 1:40 PM the number of client #3's lorazepam/Ativan 1.0 milligram/mg pills (used for seizures or panic disorders), after counting with Home Manager #1, was found to be 22.</p> <p>Review of client #1's record on 12/10/13 at 1:40 PM indicated he was prescribed 1.0 milligram/mg of lorazepam at hour of sleep daily for behavior. The record review indicated a 12/13 "Controlled Drug Record" (CDR) which listed the last pill dispensed as number 9 on 12/09/13 at 9:00 PM; it was unclear how many pills remained. The CDR form was to be used by staff to fill out in descending order to show how many pills of lorazepam were initially documented and the number remaining as the pills were dispensed on a daily basis. Starting with 30 as the initial amount, with 1 dispensed, 29 would be remaining, then 28 and so forth. The 12/13, 11/13, 10/13, 7/13, 6/13, 5/13 and 4/13 CDRs were found and reviewed in client #3's records; 9/13 and 8/13 were missing. All of the CDRs were filled out incorrectly. The facility staff (#3, #4, #5, and #6) had filled out the numbers starting with "1" to correspond to the</p>		<p>counting and documenting the disposition of controlled drugs. (Attachment E). How we will identify others: Nursing Coordinators will review Controlled Drug Audit sheets to ensure that medications are being counted correctly. Measures to be put in place: Nursing Coordinators will perform weekly home visits; including checking Controlled medication audit records to ensure medications are counted correctly (Attachment D). Monitoring of Corrective Action: Nursing Program Manager will review weekly Nursing checklist and perform bi-annual checklist, including checking Controlled medication audits for correct documentation. 1-13-2014-Addendum Nurse's Weekly Home visit checklist has been revised to include Controlled Substance audit sheet (Attachment 1). Completion Date: 1-1-2014</p>				

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	<p>numbers on the blister packages containing the lorazepam. If pill number 1 was administered, then 1 was circled on the CDR, if pill number 2 was dispensed from the blister package, number 2 was circled on the CDR and so forth.</p> <p>Review of the Food and Drug Administration's website on 12/12/13 at 10:00 AM indicated the medication lorazepam was a schedule IV controlled drug.</p> <p>Interview with staff #1 on 12/10/13 at 1:45 PM stated the facility had "always filled out" the CDRs in the manner listed above. They did not list the total amount and count down from there as pills were dispensed to give an accurate accounting of drugs remaining.</p> <p>The Director of Health Services/DHS nurse #1 was interviewed on 12/12/13 at 2:40 PM. The interview indicated the Controlled Drug Records were to be filled out in descending order so the pills remaining would be documented. The interview indicated staff were in need of retraining by the facility's recently hired LPN to dispense and document the lorazepam correctly.</p> <p>9-3-6(a)</p>			

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