

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G199	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2014
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NAME OF PROVIDER OR SUPPLIER PIKE COUNTY ARC MILL	STREET ADDRESS, CITY, STATE, ZIP CODE 400 MILL ST WINSLOW, IN 47598
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 12, 13, 14 and 15, 2014</p> <p>Facility Number: 000729 Provider Number: 15G199 AIM Number: 100243230</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/22/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure</p>	W000369	An RN has retrained the agency's LPN (Attachments A & B). The agency's LPN has demonstrated	09/15/2014

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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	<p>the medication was administered according to physician orders.</p> <p>Findings include:</p> <p>During the observation period on 8/13/14 from 5:45 AM to 7:30 AM client #1 ate her breakfast at 6:20 AM. Client #1 received her medication at 7:22 AM and client #1 received Levothyroxin 25 mg (milligram) for her thyroid during this medication pass.</p> <p>Review of the Physician Orders and MAR (Medication Administration Record) for August was conducted on 8/13/14 at 7:30 AM. The Physician Order and MAR indicated the Levothyroxin for client #1 was supposed to be given before breakfast.</p> <p>Interview with staff #2, LPN (Licensed Practical Nurse), on 8/13/14 at 2:00 PM indicated the standard practice was to give the Levothyroxin with the other medications. Staff #2, LPN indicated the Levothyroxin had been given with the other meds for some time and was not aware the medicine needed to be given before breakfast. Staff #2, LPN, indicated at 3:15 PM she had looked the medication up on the internet and it was recommended to be given on an empty stomach and before the other medicine is</p>		<p>competency to RN by taking competency test (Attachment A) and correctly transcribing physician's order (Attachment B). The LPN has retrained staff on medication administration (Attachment C). The agency LPN will observe medication passes in the home at least twice a week for four weeks using the "Medication Administration Skills Checklist" (Attachment D). If errors are observed during medication administration, the LPN will be present for med passes daily until problem is corrected. The staff will take the New Medication Competency Quiz (Attachment E) every time a new physician's order is given. The RN will visit the agency at least quarterly to review physician's orders and ensure orders are transcribed on the MAR correctly and will review the completed MARs and medication error records to ensure medications are actually being administered correctly.</p>				

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W000390	<p>given.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. Based on observation, record review and interview for 1 of 4 sampled clients (client #2), the facility failed to ensure an expired PRN (as needed) medication had been replaced and not given to the client.</p> <p>Findings include:</p> <p>Observation of the medication pass for client #2 was conducted on 8/13/14 at 7:00 AM. Client #2 requested a pill for a headache and received an acetaminophen.</p> <p>Review of the bubble pack of the acetaminophen indicated it was a PRN medication and expired on 7/8/14.</p> <p>Interview with administrative staff #1 on 8/14/14 at 1:45 PM indicated the medication is supposed to be replaced when it expires. The administrative staff #1 indicated the medicine should not</p>	W000390	<p>The facility failed to ensure expired medication was removed from the home. Client #2 was given expired PRN acetaminophen. The expired acetaminophen has been removed from home and disposed of by agency nurse.</p> <p>The agency nurse has checked the medications in all group homes and removed expired medications.</p> <p>Staff were re-trained on checking expiration dates on medications before administering them to a client. (attachments B & C) If a medication is found to be expired, staff is to send it to the agency nurse to be disposed of properly. The agency nurse will go to each group home quarterly to check for and dispose of expired medications, including PRNs and creams. The nurse will keep a record (attachment D) of when this is done which will be reviewed by the QIDP.</p>	09/04/2014

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	have been given to the client. 9-3-6(a)		Direct care staff will check expiration dates on each medication before administering it. If medication is expired, it will be sent to the nurse for disposal. The agency nurse will go to each home quarterly to check all medications and remove expired ones. The nurse will complete a checklist when this is done. The QIDP will review nurse checklist and randomly check medications in all homes for expired medications.		