

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155649	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/03/2014
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NAME OF PROVIDER OR SUPPLIER  MCCORMICK'S CREEK REHABILITATION & SKILLED NURSING	STREET ADDRESS, CITY, STATE, ZIP CODE 210 STATE HWY 43 SPENCER, IN 47460
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F000000	<p>This visit was for Investigation of Complaint IN00145825. Complaint IN00145825 - Substantiated. Federal/state deficiencies related to the allegations are cited at F281 and F332.</p> <p>Survey date: April 3, 2014</p> <p>Facility number: 010478 Provider number: 155649 AIM number: 200197620</p> <p>Survey team: Angela Patterson, RN-TC Melissa Gillis, RN Cheryl Mabry, RN Diana McDonald, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 66 Total: 75</p> <p>Census payor type: Medicare: 11 Medicaid: 51 Other: 13 Total: 75</p> <p>Sample: 05</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 10, 2014; by Kimberly Perigo, RN. 483.20(k)(3)(i) SERVICES PROVIDED MEET</p>	F000000	Preparation and/ or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F000281 SS=D				

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><b>PROFESSIONAL STANDARDS</b> The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on observation, interview, and record review, the facility failed to meet professional standards as indicated by their policy and procedure in that a nurse failed to check blood pressure prior to administering blood pressure medication and failed to have a resident rinse and spit after administering an inhaler. This deficiency had the potential to affect 2 of 2 residents randomly observed for medication administration. (Residents #C and #E) (QMA #1)</p> <p>Findings include:</p> <p>1). QMA #1 was observed to enter Resident #C's room. Resident #C was given the pill cup. Observation indicated in the pill cup was Coreg (for blood pressure). Resident #C was observed to take the pills. QMA#1 retrieved blood pressure wrist monitor and placed the monitor on Resident #C's wrist. QMA #1 took the blood pressure after the medication was given and indicated Resident #C's blood pressure was, "139/80 and pulse 80 [average range]." QMA #1 was observed to exit resident's room at that time.</p> <p>2). On 4/3/14 at 10:15 a.m., observed QMA #1 to allow Resident #E to administer [gender] own medications. QMA #1 was observed not to give Resident #E any instructions on how to use the Advair inhaler. Resident #E was observed not to rinse and spit after using the inhaler, as indicated by physician's order. QMA #1 was not observed to cue Resident #E to rinse mouth out after</p>	F000281	<p>1. The residents involved in the alleged practice was not negatively affected by the practice. 2. Residents requiring medication administration have the potential to be affected. 3. Nurses and QMAs were in-serviced on professional standards of medications. Nurses and QMAs were observed for competency and checked off on their medication administration skills check off sheet. 4. The DON or designee will do random audits on nurses and qmas across all shifts, including Saturdays and Sundays. 5x a week for 30 days. Then 3 x a week for 2 months, then once a week for 3 months. The Quality Assurance Committee will review and audit results monthly x 3 months and then quarterly with a subsequent plan developed and implemented as necessary. Failure to comply will result with one on one education and progressive discipline action if needed.</p>	04/24/2014			

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	<p>usage.</p> <p>When asked what should have been done after the administration of the inhaler, QMA #1 indicated, "[Gender] should have rinsed and spit." Was that done, "No, [gender] is so impatient."</p> <p>On 4/3/14 at 11:00 a.m., interview with Resident #E indicated when asked if [gender] always gives [gender] own medications, "Yes." When asked if [gender] knows to rinse mouth after taking the inhaler indicated, "I did." I come back in my room and rinse." Resident #E was observed in room after administering the inhaler to allow QMA #1 to administer eye drops. No rinsing out the mouth was observed and QMA #1 was not observed to cue Resident #E to rinse (gender's) mouth.</p> <p>On 4/3/14 at 11:15 a.m., received physician's order dated 10/15/13, which indicated "Advair Diskus 100 mcq-50mcq /dose powder for inhalation ... inhale 1 puff by inhalation route every 12 hours ... Protocol: Rinse Mouth following each use."</p> <p>Review of "COVENANT CARE MEDICATION ADMINISTRATION OPERATING STANDARD GUIDELINE" dated December 2012 from the DON (director of nursing) on 4/3/14 at 1:55 p.m., and indicated that it was the one currently used by the facility, "PRACTICE: Medications will be given in a manner which will prevent error related to the prescribing, dispensing, and administration, or monitoring of a drug. PROCEDURE: ... Administer from the MAR [medication administration record], not the med [medication] cart., ... Check pertinent vital signs such as HR (heart rate) and BP (blood</p>			

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F000332 SS=E	<p>pressure) prior to giving medications with parameters. ... If a medication error is discovered, stop, lock cart and report to your supervisor. A med error form will be completed, MD [medical doctor] notified, and the resident closely monitored for adverse reactions. ... Inhalers-Wash hands and don gloves. Shake as directed and use spacer if ordered. Ask resident to exhale completely then breath slow and deep through the mouth while fully depressing the canister. Wait one minute between puffs ... Rinse mouth after last puff."</p> <p>3.1-35(g)(1) 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. Eight (8) medication errors were observed during 56 opportunities for error in medication administration. This resulted in a medication error rate of 14.2%. (Resident #C, Resident #E) (QMA #1)</p> <p>Findings include:</p> <p>1). On 4/3/14 at 9:40 a.m., observed QMA #1 (qualified medical assistant) during medication administration on the North Long hall. QMA #1 was observed to dispense 9 of 14 pills indicated at 9:00 a.m., on the electronic MAR (Medication Administration Record). The pills omitted were as follows:</p>	F000332	<p>1. The residents involved in the alleged practice was not negatively affected by the practice. 2. Residents requiring medication administration have the potential to be affected. 3. Nurses and QMA were in-serviced on professional standards of medications ( Medication Administration Policy). Nurses and QMAs were observed for competency and checked off on their medication administration skills check off sheet. QMA #1 was disciplined and educated on proper practice of medication administration. 4. The DON or designee will do random audits on nurses and qmas across all shifts including Saturdays and Sundays 5 x a</p>	04/24/2014	

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	<p>1 lithium 300 mg (used for mental illness), 1 ranitidine (acid reflux) 150 mg, 1 Premarin 1.25 mg (hormone replacement), 1 oxybutynin 5 mg (treatment of bladder incontinent), 1 Coreg (blood pressure) 3.125 mg bid (twice a day),</p> <p>and flonase (nasal inhaler) was omitted. QMA #1 was observed to lock the medication cart and indicated "Ok," motioning to precede to Resident #C's room.</p> <p>When asked how many pills were in the cup, QMA #1 was observed to count the pills in the cup and indicated "9." When asked how many pills should be in the pill cup, QMA#1 indicated "14." QMA #1 was observed to check the computer MAR (medication administration record) to confirm medications to be given at 9:00 a.m. It was verified a total of 5 oral pills were omitted. There were observed 17 medications documented, on the electronic MAR, as given to Resident #C. QMA #1 indicated, "Can I start over."</p> <p>QMA #1 was observed to discard pills that were in the medication cup and pull pill cards from the medication cart. QMA #1 was observed to dispense 2 lithium pills, ranitidine, Premarin, oxybutynin, Coreg, and gluconate rinse that were missing in the first dispensing. QMA #1 indicated when asked how many pills were dispensed, "14."</p> <p>QMA #1 was observed to enter Resident #C's room. Resident #C was given the pill cup. Resident #C was observed to take the pills. QMA #1 retrieved a blood pressure wrist monitor and placed the wrist monitor on Resident #C's wrist. QMA #1 indicated when asked what was Resident #C's blood</p>		<p>week for 30 days. Then 3 x a week for 2 months, then once a week for 3 months. The Quality Assurance Committee will review the audit results monthly x 3 months and then quarterly with a subsequent plan developed and implemented as necessary. Failure to comply will result with one on one education and progressive discipline action if needed.</p>		

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	<p>pressure "139/80 and pulse 80 [average range]." QMA #1 was observed to exit resident's room at that time.</p> <p>When asked about the flonase, QMA #1 indicated, "Oh, I don't see it, I have to find out where its at. I'll ask nursing supervisor, she'll probably have it sent out." When asked what is protocol when medication is not available, QMA #1 indicated, "Well I tell the nursing supervisor, and if it is in the emergency pharmacy kit, well I don't think flonase would be in there. I guess it will be a missed dose."</p> <p>Review of physician's orders dated 2/4/14 received from the ADON (assistant director of nursing) on 4/3/14 at 12:15 p.m., indicated " lithium carbonate 300 mg tablet ... give 2 tablet (600) mg by oral route 2 times per day ... Diagnosis: ... Bipolar disorder ... Fluticasone 50 mcq/... nasal spray (flonase) ... inhale 1 spray ... one daily, ... Diagnosis: ... Allergic rhinitis ..." Also included were, ranitidine 150 mg (acid reflux) daily, Premarin 1.25 mg (hormone replacement) daily, oxybutynin 5 mg (treatment of bladder incontinent) daily, and Coreg (blood pressure) 3.125 mg bid (twice a day),</p> <p>2). On 4/3/14 at 10:15 a.m., observed QMA #1 to allow Resident #E to administer [gender] own medications. QMA #1 was not observed to give Resident #E any instructions on how to use the Advair inhaler. Resident #E was not observed to rinse and spit after using the inhaler, as physician's order. QMA #1 was not observed to give resident any cueing in regard to rinsing. When asked if rinsing should have been done after the administration of the inhaler, QMA #1 indicated, "[Gender] should have rinsed and spit." Was that done, "No,</p>			

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	<p>[gender] is so impatient."</p> <p>On 4/3/14 at 11:00 a.m., interview with Resident #E indicated when asked if [gender] always gives [gender] own medications, "Yes." When asked if [gender] knows to rinse mouth after taking the inhaler indicated, "I did." I come back in my room and rinse." Resident #E was observed in room after administering the inhaler to allow QMA #1 to administer eye drops. No rinsing out the mouth was observed. QMA #1 was not observed to cue Resident #E to rinse.</p> <p>On 4/3/14 at 11:15 a.m., received physician's order dated 10/15/13 which indicated, "Advair Diskus 100 mcq-50 mcq /dose powder for inhalation ... inhale 1 puff by inhalation route every 12 hours ... Protocol: Rinse Mouth following each use."</p> <p>Review of "COVENANT CARE MEDICATION ADMINISTRATION OPERATING STANDARD GUIDELINE" dated December 2012 from the DON (director of nursing) on 4/3/14 at 1:55 p.m., and indicated that it was the one currently used by the facility. "PRACTICE: Medications will be given in a manner which will prevent error related to the prescribing, dispensing, and administration, or monitoring of a drug. PROCEDURE: ... Administer from the MAR [medication administration record], not the med [medication] cart., ... Check pertinent vital signs such as HR (heart rate) and BP (blood pressure) prior to giving medications with parameters. ... If a medication error is discovered, stop, lock cart and report to your supervisor. A med error form will be completed, MD [medical doctor] notified, and the resident closely monitored for adverse reactions. ... Inhalers-Wash hands and don</p>			

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	gloves. Shake as directed and use spacer if ordered. Ask resident to exhale completely then breath slow and deep through the mouth while fully depressing the canister. Wait one minute between puffs ...Rinse mouth after last puff."  3.1-48(c)(1)			