

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 11/12/2015
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NAME OF PROVIDER OR SUPPLIER  SENIOR SUITES AT THE LELAND, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374
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R 0000  Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00177605 completed on August 17, 2015.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00184600.</p> <p>Complaint IN00177605-Not corrected.</p> <p>Survey dates: November 9, 11 and 12, 2015</p> <p>Facility number: 012497 Provider number: 012497 AIM number: N/A</p> <p>Census bed type: Residential: 89 Total: 89</p> <p>Census Payor type: Medicaid: 64 Other: 25 Total: 89</p> <p>Sample: 5</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R 0000		

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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R 0091  Bldg. 00	<p>Quality review completed by 30576 on November 16, 2015.</p> <p>410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request. Based on interview, the facility failed to ensure policies were developed for administration of medications to facility residents. This deficient practice has the potential to adversely affect the care and services to all residents to whom the facility administers medications.</p> <p>Findings include:</p> <p>In an interview with the Executive Director on 11-12-2015 at 1:25 p.m., he indicated he was unable to locate any policies related to medication administration.</p> <p>In an interview with the Director of Nursing on 11-12-2015 at 1:30 p.m., she indicated she could not locate any</p>	R 0091	<p>A Medication Administration policy was located and reviewed. A new revised Medication Administration has been implemented. (Attachment A) All residents who the facility administrator's medicationsto had the potential to be affected by this deficient practice, a new revisedpolicy has been implemented. (Attachment A) A new revised policy has been implemented for MedicationAdministration. (Attachment A) A review of The Leland Legacy Policy and Procedures is currently underway to ensure all State Residential Regulations are met. A systemic audit will occur with at least 3policies reviewed and revised as needed per week, by the</p>	12/01/2015

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R 0241 Bldg. 00	<p>policies related to medication administration.</p> <p>This deficiency was cited on 8-17-15. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>5-1.3(h)(1) 5-1.3(h)(4)</p> <p>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.</p> <p>Based on observation, interview and record review the facility failed to ensure qualified medication aides (QMA) administer PRN (as needed) medications when authorized by a licensed nurse or physician prior to the administration of the medication, as well as facility staff administer medications as ordered by the resident's physician for 1 of 1 QMA's during 1 of 2 medication pass observations for 2 of 6 residents with 1 of 2 staff members. (Resident #P and</p>	R 0241	<p>Executive Director or designee. This will be on-going until all policies and procedures have been reviewed and/or revised as needed. (Attachment B)</p> <p>All staff (Nurses and QMA's) who administer medications have been inserviced on the revised Medication Administration policy. (Attachment A). Nurses have been inserviced on the new recapitulation policy, (Attachment C). There is no corrective action that can be taken to correct the deficient practice for the resident(s) who were affected. No adverse reactions were noted as a result of the deficient practice. All resident who the facility provides</p>	12/01/2015

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	<p>Resident #Q)</p> <p>Findings include:</p> <p>1. During a medication pass observation on 11-9-15 at 6:49 p.m., with QMA #1, she prepared and administered the evening medications for Resident #Q. These medications included, but were not limited to, Tramadol 50 mg (milligrams), 2 tablets, indicated to be administered every 6 hours PRN. Resident #Q had requested this specific medication for "all over" pain. QMA #1 was not observed to discuss the administration of this PRN with LPN #2 who was present in the medication preparation area with QMA #1 prior to administration of the PRN medication.</p> <p>During a medication pass observation on 11-9-15 at 6:55 p.m., with QMA #1, she prepared and administered the evening medications for Resident #P. These medications included Norco 10/325 mg, indicated to be administered every 4 to 6 hours PRN. Resident #P had requested this specific medication for a headache. QMA #1 was not observed to discuss the administration of this PRN with LPN #2 who was present in the medication preparation area with QMA #1 prior to administration of the PRN medication.</p>		<p>medicationadministration to had the possibility to be affected, no other residents wereidentified to be affected.</p> <p>A revised Medication Policy has been implemented and theappropriate staff have been inserviced on the proper policy and procedureregarding Medication Administration. Additionally,a policy regarding the monthly recapitulation of Physician Orders has beenwritten and implemented. The appropriatestaff have been inserviced on this new policy. The DON or designee will audit (Attachment D) to ensure theMedication Administration policy is followed, by an audit process of no lessthan 5 residents each scheduled day of work for the first 4 weeks at which timeif the staff are properly documenting the administration of medication, theaudit will decrease to 15 residents per week for the 8 weeks, then decline to 5residents per week for 12 weeks. Additionally,the DON or designee will review the Physician Orders recapitulations monthlyprior to the beginning of the month to ensure the Medication AdministrationRecord is accurate with the current Physician Orders, this will be on-going(Attachment C). An inservice calendarhas been developed to ensure the Nursing staff are receiving proper training tomeet the State Residential Regulations.</p>				

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	<p>In an interview with QMA #1 on 11-9-15 at 7:05 p.m., she indicated the QMA staff "are supposed to talk with the nurse about it [administering a PRN medication] and get it OK'd before we give it. Then the nurse will co-sign it or initial it. It gets real busy in here during med time. No, I did not say anything to the nurse about it before I gave the PRN's."</p> <p>A request to review the facility's policies and/or procedures regarding medication administration was made to the Director of Nursing and the Executive Director on 11-12-15. Both indicated the facility does not currently have any such policies or procedures.</p> <p>2. During a medication pass observation on 11-9-15 at 6:55 p.m., with QMA #1, she prepared and administered the evening medications for Resident #P. These medications included Valium 5 mg (milligrams) and Melatonin 3 mg. The Medication Administration Record (MAR) indicated the orders for these medications to be Valium 5 mg, 1/2 tablet by mouth daily in the morning and 1 tablet at bedtime and Melatonin 3 mg one tablet daily at bedtime. The administration time for both medications was indicated to be 7:00 p.m. to 9:00 p.m. Review of the October and November, 2015 MAR indicated both</p>			

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	<p>medications had been administered as indicated, with the exception of 3 doses of Melatonin during this time period.</p> <p>Review of Resident #P's clinical record on 11-12-15 at 10:15 a.m., indicated the two most current recapitulation orders in the clinical record, for September and October, 2015, indicated an absence of any physician orders for Valium and Melatonin. Review of the clinical record indicated Resident #P had been discharged from an area hospital on 6-19-15 with admission orders to the facility for Valium 5 mg, 1/2 tablet by mouth daily in the morning and 1 tablet at bedtime and Melatonin 3 mg one tablet daily at bedtime. A copy of a written prescription, dated, 7-22-15, indicated an order for Valium 5 mg with the above instructions for 45 tablets of the medication with 2 refills authorized by the physician. The recapitulation orders for July, 2015 and August, 2015 included the orders for administration for the Valium 5 mg and Melatonin 3 mg.</p> <p>In an interview with the Consultant Pharmacist on 11-12-15 at 12:45 p.m., he indicated, "I will have to take some responsibility for [name of Resident #P]'s monthly orders not printing completely. For some reason, there seems to be a software problem."</p>			

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	<p>In an interview with the Executive Director on 11-12-15 at 5:35 p.m., he indicated that although the pharmacy accepted responsibility for the recapitulation orders not being correct, he indicated the facility had to also accept responsibility, "Because our nurses weren't checking the monthly rewrites. But, that goes back to not having policies and procedures in place."</p> <p>In an interview with the Executive Director on 11-12-2015 at 1:25 p.m., he indicated he was unable to locate any policies related to medication administration.</p> <p>In an interview with the Director of Nursing on 11-12-2015 at 1:30 p.m., she indicated she could not locate any policies related to medication administration.</p> <p>This deficiency was cited on 8-17-15. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>5-1.4(e)(2)</p>			