

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/31/2012
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NAME OF PROVIDER OR SUPPLIER GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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F0000	<p>This visit was for the Recertification and State Licensure Survey.</p> <p>Survey dates: May 29, 30, and 31, 2012.</p> <p>Facility number : 000288 Provider number : 155743 AIM number : 100287380</p> <p>Survey team : Michelle Hosteter RN-TC Michelle Carter, RN Rita Mullen , RN</p> <p>Census bed type: SNF/NF : 46</p> <p>Census payor type : Medicare : 3 Medicaid : 29 Other : 14 Total : 46</p> <p>Sample: 11</p> <p>Green-Hill Manor was found to be in substantial compliance with 42 CFR Part 483, Subpart B in regards to the Recertification and State Licensure Survey.</p> <p>These deficiencies reflect state findings</p>	F0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>	

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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	cited in accordance with 410 IAC 16.2. Quality review completed on June 6, 2012 by Bev Faulkner, RN				

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F0431 SS=A	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation and interview, the facility failed to up-date the label on a medication container when the physician changed the frequency of the medication.</p>	F0431	<p>1. Resident #44 received the appropriate medication dosage. A "direction change" sticker was immediately applied to the medication container. 2. The</p>	06/30/2012			

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	<p>This effected 1 of 9 Residents observed during medication pass. (Resident #44)</p> <p>Findings include:</p> <p>During the medication pass observations on 5/29/12 at 12:00 P.M., the medication container for Alprazolam (an Anxiolytic-generic for Xanax) indicated Resident #44 was to receive 0.5 milligrams at bedtime and every 6 hours as needed.</p> <p>The physician's order, dated 12/9/11, indicated , "Discontinue Xanax 0.25 mg po (by mouth) q (every) 8 (hour sign). Begin Xanax 0.5 mg po q 8 (hour sign) routinely. Continue 0.5 mg po q 6 (hour sign) prn for (arrow up) increased anxiety or agitation."</p> <p>The Medication Administration Record, dated for the month of May 2012, indicated the Alprazolam was to be administrated routinely every 8 hours as ordered by the physician.</p> <p>During an interview with LPN #1 on 5/29/12 at 12:02 P.M., she indicated the facility had labels for the medication containers that were to be used when a medication frequency was changed, and that the pharmacy would have to be called.</p>		<p>orders of all residents were reviewed and compared to the medication containers for all other residents in the facility and identified concerns were immediately corrected. 3. The licensed staff will be re-educated on the policy and procedure for Prescription Label changes. The Director of Nursing or designee will review all physician orders 5X weekly for any medication changes. The medication containers will be visually inspected to ensure that the "change of directions" stickers have been applied. Any findings will be immediately corrected. These reviews will continue indefinitely.4. The findings of these reviews will be reported to the QAA committee monthly X 3 months and then quarterly.5. 6/30/12</p>		

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	<p>During an interview with the Assistant Director of Nursing on 5/31/12 at 9:45 A.M., she indicated there is a process for changing labels when the orders have been changed. A new label is put on the container and the pharmacy then changes the label.</p> <p>3.1-25(j)</p>			

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F0514 SS=A	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review, and interview, the facility failed to maintain accurate documentation on a Physician's Order Sheet and a Medication Administration Record (MAR) regarding medication administration times. This affected 1 of 17 residents reviewed for maintaining complete and accurate documentation. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record for Resident #2 was reviewed on 5/30/12 at 8:50 A.M.</p> <p>Diagnoses for Resident #2 included, but were not limited to, dementia, depression, macular degeneration, high blood pressure, peripheral-vascular disease, hypothyroidism, and anemia.</p>	F0514	<p>1. The physician was contacted for resident #2 and an order clarification was received for the Aricept to be given at 8:00pm. 2. The orders of all residents in the facility were reviewed to ensure the medication orders and the administration times were consistent. Any identified concerns were immediately corrected.3. The licensed staff were re-educated on the policy and procedure for Checking Physician's Order Recaps. The Director of Nursing or designee will review all physician's order recaps monthly to ensure the administration of instructions are correct. Any findings will be immediately corrected and the clinical record provider notified as per policy. This review will continue indefinitely. 4. The findings of these reviews will be reported to the QAA committee montly X 3 months and then</p>	06/30/2012			

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	<p>A Physician's Order Sheet dated for the month of May 2012 and signed by the attending physician on 5/13/12, indicated, in the medications column, an order for Aricept 10 mg (milligrams) tablet, take one tablet by mouth every evening at 5:00 P.M. The order was dated 3/12/09. In the column indicating administration time, the entry stated 8:00 P.M. as the time the Aricept 10 mg was to be given, not 5:00 P.M. The MAR for the month of May 2012 included the same information.</p> <p>During an interview with LPN #1, she indicated she was not sure how long the Aricept 10 mg was administered at 8:00 P.M. instead of 5:00 P.M. She indicated that Aricept is typically ordered to be administered at bedtime and not in the afternoon. The time discrepancy had not been clarified with the physician.</p> <p>3.1-50(a)(2)</p>		quarterly. 5. 6/30/12		