STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155678		07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00202622. Complaint IN00202622 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: June 29, 30, July 1, 5, 6, 7 and 8, 2016 Facility number: 002667 Provider number:155678 AIM number: 200300090 Census bed type: SNF/NF: 44 SNF: 35 Residential:40 Total: 119 Census payor type: Medicare: 25 Medicaid: 29 Other: 25 Total: 79 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Complaint (IN00202622) Survey on July 8, 2016. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality Review was completed by 21662 on July 15, 2016.			
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview the facility failed to ensure a resident received the appropriate treatment for possible bladder infection per order of the Nurse Practitioner. Resident was not provided the laboratory testing needed to rule out urinary tract infection for 1 of 5 residents reviewed for unnecessary medications. (Resident #54). Findings include:	F 0315	**F 315** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #54 assessed and displays no signs or symptoms of bladder infection / UTI. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS	08/07/2016

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	The record for Resident #54 was reviewed on 7/6/16 at 3:00 p.m. Diagnoses included, but were not limited to, urinary tract infection, dementia, mood disorder, psychotic disorder with delusions. A progress note dated 5/03/16 from the facility Nurse practitioner indicated: Nursing has asked writer to assess the patient today secondary to altered mental status, history of urinary tract infections with symptoms very similar to behaviors at this time when has been positive in the past. Medication review: The patient is not currently on any antibiotic therapy. Is currently ordered Ativan 0.5 mg po (by mouth) bid (two times daily) PRN at this time. This will be increased. Plan: Diagnosis:1. Urinary tract infection. Investigations ordered: urinalysis with micro and culture and sensitivity. Straight catheterization for sample. Medications Prescribed and Plan: 1. Will be treating with antibiotic per culture and sensitivity results when results are available for review if positive and we will follow up next week for further evaluation. The Treatment Administration Record dated 5/04/16 at 3:43 a.m. indicated urinalysis not administered: Refused. During an interview on 7/07/16 at 11:13		or designee will review MD/NP orders for the past 7 days on all residents to ensure the resident received appropriate treatment as ordered. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following guideline: Medication Orders **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance. Monitoring / auditing of this plan of correction will occur on all shifts: review MD / NP orders for the to ensure the resident received appropriate treatment as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	a.m., the facility Nurse Practitioner indicated he was not notified the urinalysis was not completed for Resident #54. He also indicated he would have had the staff retry the straight catheterization or obtain a clean catch urine specimen. He indicated he is no longer writing orders for resident due to hospice status. During an interview on 7/07/16 at 1:13 p.m., the Assistant Director of Health Services indicated when staff is unable to follow a physician/nurse practitioner order, the physician or nurse practitioner should be notified. She indicated the facility nurse practitioner is at facility daily and could be notified during his rounds. A review of the current policy Medication Orders" dated 9/1/13, indicated "...Policy: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe... a. New Handwritten Orders 1. By the Prescriber while present in the facility a) the nurse on duty at the time the order is received enters it on the physician order sheet/telephone order sheet) if not written there by the Prescriber, and notes the order as follows: ... b) if necessary, the order is obtained before the Prescriber			

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	leaves the nursing station...." 3.1-41(a)(2)			
F 0328 SS=D Bldg. 00	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on record review, observation and interview, the facility failed to ensure the recommended treatment from a consultant for foot care was performed for 1 of 1 resident reviewed for activities of daily living. (Resident #3). Findings include: During a review of the record on 7/6/16 at 10:00 a.m., diagnoses included, but were not limited to, dementia without behavioral disturbance, malignant melanoma, anemia, peripheral vascular disease, keratoderma, xerosis. Resident #3 was seen by Podiatrist on	F 0328	**F 328 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #3 order reviewed and feet observed to ensure she is receiving the recommended foot care treatment as ordered by the consultant (podiatrist). **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review the most recent recommendations from the podiatrist and observe the resident's feet to ensure foot care is performed as ordered. **Measures put in place and**	08/07/2016

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	2/5/16: Exam Summary by [name of Podiatrist] indicated "...#1. Presenting Problem/Chief Complaint Evaluated: dry skin-both feet, #2. Presenting Problem/Chief Complaint Evaluated: nails long-both feet,#3. Presenting Problem/Chief Complaint Evaluated: nails-painful-both feet, #4. Presenting Problem/Chief Complaint Evaluated: nails-thick both feet...Procedures &Plan: treated xerosis using a Therapeutic Lotion. Instructions: Follow the medications and treatments as follows: recommend emollient daily to both feet...." Resident #3 was seen by Podiatrist on 4/7/16: Exam Summary by [name of Podiatrist] indicated "...#1. Presenting Problem/Chief Complaint Evaluated: dry skin-both feet, #2. Presenting Problem/Chief Complaint Evaluated: nails long-both feet, #3. Presenting Problem/Chief Complaint Evaluated: nails-painful-both feet, #4. Presenting Problem/Chief Complaint Evaluated: nails-thick both feet...Procedures &Plan: treated xerosis using a Therapeutic Lotion. Instructions: Follow the medications and treatments as follows: recommend emollient daily to both feet...." During an observation of Resident #3 feet		**systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following guideline: Prescriber Medication Orders **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review the most recent recommendations from the podiatrist and observe the resident's feet to ensure foot care is performed as ordered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	on 7/7/16 at 1:50 p.m., her feet were noted to be dry and scaly. During an interview with LPN#1 on 7/7/16 at 1:55 p.m., she indicated the order on the Medication Administration Record (MAR) read topical trimicolone 0.1% (corticosteriod cream) apply to right leg. She did not apply any cream to her feet and was not aware of the order for both feet. A review of current policy received from clinical Support Nurse on 7/1/16 at 2:10 p.m., titled "Prescriber Medication Orders" dated 9/1/13, indicated "...Policy...Medications are administered only upon the clear, complete and signed order of a person...) 3) Standing orders are accepted for (prescription medications, treatments, and non prescription medications)...The nurse implementing the standing order (s) adds the order to the MAR...." 3.1-47(a)(7)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications			

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	for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on record review and interview, the facility failed to ensure psychotropic and antianxiety medications were administered per physician order and failed to ensure antianxiety medication dose was not increased without appropriate indication for use and monitored for continued use for 2 of 3 residents reviewed for unnecessary medications.(Resident #79, Resident #61). Findings include: 1. During a review of the record for Resident #79 on 7/1/16 at 1:30 p.m., diagnoses included, but were not limited to, Alzheimer's disease, difficulty walking, muscle weakness, hypertension, chronic kidney disease, other depressive	F 0329	**F 329 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** 1). Resident #79 dosage reduction for Zyprexa, Ativan and Remeron was completed and medications are being administered per MD order. 2). Resident #54 medications will be reviewed by MD to ensure appropriate and indication for use is in place. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review the following for all residents: 1). The most recent Psychiatric Progress Notes to ensure medications are being administered per order 2). All residents receiving psychotropic	08/07/2016

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	disorders generalized anxiety disorder. The current physician's orders of June 2016 indicated an order for ativan (antianxiety) 1mg (milligram) four times daily, Remeron (antidepressant) 45 mg at bedtime, Zyprexa (antipsychotic) 2.5 mg daily for on three days a week,(Monday, Wednesday and Friday). A review of the Psychiatry Progress Note and Treatment Summary dated 6/21/16, indicated pyschotropic medications were reviewed. Dosage reduction was indicated. The Impression and plan was: 1. Discontinue (d/c) Zyprexa 2. Begin Klonopin 0.5 mg three times a day, d/c Ativan 1 mg four times daily 3. Decrease Remeron to 30 mg every night 4. Pain treatment: Hydrocodone 5-325 mg three times daily A review of the Medication Adminsitration Record indicated on 7/1/16, Resident #79 continued to receive Zyprexa, Ativan and Remeron 45 milligram dosage. During an interview with LPN#2 on 7/1/16 at 1:20 p.m., she indicated she was not aware of the medication changes written by the consulting psychiatrist and would expect consultant to give her new		medications to ensure dose was not increased without appropriate indication for use and behavioral indicators are being monitored for continued use. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1). Psychotropic Medication Usage and Gradual Dose Reduction 2). Medication Orders **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). Most recent Psychiatric Progress Notes to ensure medications are being administered per order 2). Residents receiving psychotropic medications to ensure dose was not increased without appropriate indication for use and behavioral indicators are being monitored for continued use. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	orders when he wrote them so they could be implemented. 2. The record for Resident #54 was reviewed on 7/6/16 at 3:00 p.m. Diagnoses included, but were not limited to, urinary tract infection, dementia, mood disorder, and psychotic disorder with delusions. A progress note dated 5/03/16 from the facility Nurse practitioner indicated: Nursing has asked writer to assess the patient today secondary to altered mental status, history of urinary tract infections with symptoms very similar to behaviors at this time when has been positive in the past. Medication review: The patient is not currently on any antibiotic therapy. Is currently ordered Ativan 0.5 mg po (by mouth) bid (two times daily) PRN (as needed) at this time. This will be increased. Plan: Diagnosis:1. Urinary tract infection. Investigations ordered: urinalysis with micro and culture and sensitivity. Straight cath for sample. Medications Prescribed and Plan: 1. Will be treating with antibiotic per culture and sensitivity results when results are available for review if positive and we will follow up next week for further evaluation. 2. Also additional order, will be increasing Ativan 0.5 mg po bid to tid (three times daily) PRN. Continue to monitor for effectiveness.			

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	A Nurse Practitioner order dated 5/03/16 indicated Ativan 0.5 mg TID (three times day) PRN(as needed). Continue to monitor for effectiveness. A review of Behavior tracking for dates 5/1/16, 5/2/16 and 5/3/16 indicated no behaviors. A review of Medication Administration Record (MAR) for the dates 5/1/16, 5/2/16 and 5/3/16 indicated no Ativan PRN was given. The Treatment Administration Record dated 5/04/16 at 3:43 a.m., indicated urinalysis not administered: Refused. During an interview on 7/07/16 at 11:13 a.m., the facility Nurse Practitioner indicated he was not notified the urinalysis was not completed for Resident #54. He also indicated he would have had the staff retry the straight cath or obtain a clean catch urine specimen. He indicated he is no longer writing orders for resident due to hospice status. During an interview on 7/07/16 at 1:13 p.m., the Assistant Director of Health Services indicated when staff is unable to follow a physician/nurse practitioner order, the physician or nurse practitioner			

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	should be notified. She indicated the facility nurse practitioner is at facility daily and could be notified during his rounds. A current policy titled "Psychotropic Medication Usage and Gradual Dose Reductions" dated 05/10/16 was provided by the Social Services Designee on 7/1/16 at 2:10 p.m. The policy indicated"...To ensure every effort is made for residents receiving psychoactive medications obtain the maximum benefit with minimal unwanted side effects through appropriate use, evaluation and monitoring by the interdisciplinary team...1. Residents shall receive psychotropic medications only if designated medically necessary by the prescriber, with appropriate diagnosis or documentation to support its usage. The medical necessity will be documented in the resident's medical record and in the care planning process. 2. Regular monthly review of antipsychotics in CAR(clinically at risk) for continued need, appropriate dosage, side effects, risks and/or benefits will be conducted, to ensure the use of psychopharmacologic medications are therapeutic and remain beneficial to the resident...." A review of the current policy Medication Orders" dated 9/1/13,			

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	indicated "...Policy: Medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe... a. New Handwritten Orders 1. By the prescriber while present in the facility a) the nurse on duty at the time the order is received enters it on the physician order sheet/telephone order sheet) if not written there by the prescriber, and notes the order as follows... b) if necessary, the order is obtained before the prescriber leaves the nursing station...." 3.1-48(a)(3) 3.1-48(c)(2)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review the facility failed to ensure expired foods were discarded and foods were dated when opened in 1 of 1 kitchens. This deficient practice had the potential to affect 78 of 79 residents who received food from the kitchen.	F 0371	**F 371 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Audit / observation of storage areas in the kitchen to ensure food items have been dated and labeled when opened and expired foods have been discarded. **Identification of**	08/07/2016

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	Findings include: During the tour of the kitchen on 6/29/16 at 8:40 a.m., with the Director of Food Services, the following observations were made: The walk in freezer was observed to have: One box of danish rolls opened and not dated. Three containers of ice cream opened and not dated. The walk in cooler was observed to have: One bag of parsley with best by date 6/4/16 and no facility use by date. One container of strawberries opened and not dated. One bag of limes opened and not dated. One box of celery opened and not dated. One bag of shredded carrots with best if used by date 6/10/16 and no facility use by date. One bag of shredded carrots with best if used by date 6/14/16 and no facility use by date. One box of fresh lettuce dated 6/20/16 and no facility use by date. Three trays of prepared desserts in individual containers not dated. One box of hot dogs opened 6/20/16 and no use by date. One container of chicken and noodles		**other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: Food Labeling and Dating **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Audit / observation of storage areas to ensure food items have been dated and labeled when opened and any expired foods have been discarded. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155678	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/08/2016
NAME OF PROVIDER OR SUPPLIER WATERFORD PLACE HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE 800 ST JOSEPH DR KOKOMO, IN 46901	

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	with prepared date of 6/25/16 and use by 6/28/16. One container of tomato soup with prepared date of 6/25/16 and use by date of 6/28/16. Kitchen preparation area was observed to have: One large Rubbermaid container of oatmeal (out of original package) not dated. One large Rubbermaid container of flour (out of original package) with prepared date of 6/27 and no use by date. One bottle of hot sauce opened and not dated. One bottle of A-1 sauce opened and not dated. One bottle of pure vanilla opened and not dated. One bottle caramel sauce opened and not dated. Eighteen bottles of spices opened and not dated. One bottle of butter oil out of original package and not dated. The kitchen freezer was observed to have: One box of ground beef patties opened and not dated. Two packages of chicken strips opened and not dated. One package of chicken patties opened			

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	and not dated. One package of tilapia opened, not sealed and not dated. One package of fries opened 6/28/16 and no use by date. The bread cart in kitchen was observed to have: One package of prepared biscuits dated 6/28/16 and no use by date. The dry storage area was observed to have: One bottle of garlic herb seasoning opened and not dated. One metal shaker container of cinnamon not labeled and not dated. One container of baking soda opened and not dated. One bottle of imitation maple opened and not dated. One container of ground ginger opened and not dated. Three packages of instant pudding opened and not dated. One package of brownie mix opened and not dated. One package of cinnamon streusel opened and not dated. One package of dry mashed potatoes opened and not dated. One package of chocolate chips out of original package with no use by date. One package of coconut opened and not			

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	dated One package of walnuts opened and no use by date. One crispy fry mix opened and no use by date. One bottle of browning seasoning liquid opened and not dated. One package of raisins opened and not dated. During a tour of the kitchen on 6/30/16 at 2:47p.m. with the Executive Director and The Director of Food Services the following observations were made: The kitchen refrigerator was observed to have: Two bottles of tomato juice opened and not dated. One bottle of ketchup with no use by date. During a tour of the kitchen on 7/07/16 at 1:57 p.m., with the Executive Director and The Director of Food Services the following observations were made: The walk in freezer was observed to have: One pail of vanilla ice cream opened and not dated. The walk in cooler was observed to have: One package of celery opened and not			

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	dated. The kitchen refrigerator was observed to have: One bottle of grape juice opened and no use by date. During an interview on 6/29/16 at 9:22 a.m.,the Director of Food Services indicated all employees have had inservice on the labeling system for all foods to have label with date opened and use by date. A current policy titled "Food Labeling and Dating Policy" received from the Food Services Director on 6/29/16 at 10:50a.m., indicated "...Food Labeling. Any food product: Removed from its original container. Has the seal broken. That has been processed or prepared in any way. MUST have a label that contains the following: Item name. Date and Time (that the food was labeled). Use BY date...." 3.1-21(i)(3)			
F 0431	483.60(b), (d), (e)			

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SS=D Bldg. 00	DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. 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.			
	Based on observation, interview and record review the facility failed to ensure expired medications and medications that were brought in by family were disposed of per facility policy for 1 of 5	F 0431	**F 431 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #61 expired medication was disposed of per	08/07/2016

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	medication carts reviewed. (Resident # 61) Findings include: During an observation of the Medication Cart for the 300 hall on 7/06/16 at 9:47 a.m., with LPN #2 the following observations were made: The following were labeled with Resident #61: One bottle of Tylenol 500 mg with expiration date of 05/16. One bottle of exforge 5-320 from (Name of Pharmacy) dated 8/2/15. One bottle of metformin 500mg from (Name of Pharmacy) dated 9/14/15. One bottle of levothyroxin 75 mcg from (Name of Pharmacy) dated 8/2/15. One bottle of dulcolox 100 mg from (Name of Pharmacy) dated 8/24/15. One bottle of buspirone 10 mg from (Name of Pharmacy) dated 8/2/15. During an interview on 7/06/16 at 9:52 a.m., LPN #2 indicated she was not sure why the (Name of Pharmacy) medications for Resident #61 were in the medication cart since staff were not using these medications and were using the foil packs of medication. She also indicated all staff were responsible to look at expiration dates on medication.		facility policy. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will audit all medication carts to ensure any expired medications have been disposed of per facility policy. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the licensed nursing staff on the following: 1). Medication Storage in the Facility 2). Medication Ordering and Receiving from Pharmacy**How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: audit of all medication carts to ensure any expired medications have been disposed of per facility policy. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	A current policy titled "Medication Storage in the Facility" dated 9/1/13 was provided by the Executive Director on 7/7/16 at 8:20 a.m. The policy indicated"...L. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures fro medication disposal...." A current policy titled "Medication ordering and Receiving from Pharmacy" dated 9/1/13 was provided by the Executive Director on 7/8/16 at 10:57 a.m. The policy indicated "...Medications brought into the facility by a resident or family members are used only upon written order by the resident's attending physician, after the contents are verified, and if the packaging meets the facility's guidelines. Unauthorized medications are not accepted by the facility. ...C. Medications not ordered by the resident's physician, or unacceptable for other reasons, are returned to the family or designated agent. If unclaimed within thirty days, the medications are disposed of in accordance with facility medication destruction/disposal procedures...." 3.1-25(o)			

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey Residential Census: 40 Sample: 11 This State finding is cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Recertification and State Licensure Survey in conjunction with Complaint (IN00202622) Survey on July 8, 2016. Please accept this plan of correction as the provider's credible allegation of compliance.	

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			The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review the facility failed to ensure foods were dated when opened in 1 of 1 kitchens. This deficient practice had the potential to affect 40 of 40 residents who received food from the kitchen. Findings include: During the tour of the kitchen on 6/29/16 at 9:53a.m. with the Director of Food Services, the following observations were made: The kitchen refrigerator was observed to have: One bottle of apple juice opened and no use by date. One jar of olives opened and no use by date. One package of cheese slices opened and	R 0273	**R 0273 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Audit / observation of all storage areas in the kitchen to ensure food items have been dated and labeled when opened and expired foods have been discarded. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents have the potential to be affected by this alleged deficient practice. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Dietary Manager or designee will re-educate the Dietary Team on the following campus guidelines: Food Labeling and Dating **How the corrective measures will be**	08/07/2016

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	not dated. One bag of shredded mozzarella cheese opened and no use by date. One package of ham chunks opened and no use by date. One bag of whipped cream opened and not dated. One package hamburger thawing with date of 6/27 and no use by date. The kitchen freezer was observed to have: One package of frozen cookie dough opened and not dated. One package of frozen waffles opened and not dated. One package of chicken strips with no use by date. One package of catfish with no use by date. During an interview on 6/29/16 at 9:22 a.m., the Director of Food Services indicated all employees have had inservice on the labeling system for all foods to have label with date opened ad use by date. A current policy titled "Food Labeling and Dating Policy" received from the Food Services Director on 6/29/16 at 10:50 a.m., indicated "...Food Labeling. Any food product: Removed from its original container. Has the seal broken.		**monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations will be conducted by the Dietary Manager or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Audit / observation of all storage areas to ensure food items have been dated and labeled when opened and any expired foods have been discarded. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	That has been processed or prepared in any way. MUST have a label that contains the following: Item name. Date and Time(that the food was labeled). Use BY date...."			