

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155472	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2015
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NAME OF PROVIDER OR SUPPLIER HOOSIER VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 9875 CHERRYLEAF DR INDIANAPOLIS, IN 46268
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180223.</p> <p>Complaint IN00180223 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 23, 24, 2015</p> <p>Facility number: 000548 Provider number: 155472 AIM number: N/A</p> <p>Census bed type: SNF: 19 NCC: 56 Residential: 137 Total: 212</p> <p>Census payor type: Medicare: 12 Other: 63 Total: 75</p> <p>Sample: 3</p> <p>Hoosier Village was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00180223.</p>	F 0000	<p>This plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law.</p>	
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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 0000 Bldg. 00	Quality review completed 9/28/15 by 29479. This visit was for the Investigation of Complaint IN00180223. Complaint IN00180223 - Substantiated. State residential deficiencies related to the allegations are cited at R241 and R 297 Residential census: 137 Sample: 3 These state findings are cited in accordance with 410 IAC 16.2-5.	R 0000	This plan of correction constitutes the written compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet the requirements established by the state and federal law.	
R 0241 Bldg. 00	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. Based on record review and interview, the facility failed to ensure medications were available and administered according to physician's orders for 1 of 3 residents reviewed for medication	R 0241	Resident E has had her Levothyroxine since September 21, 2015 without any interruptions. No other residents were affected.It is the policy of this facility to ensure medications	10/13/2015

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	<p>administration. (Resident E)</p> <p>Finding includes:</p> <p>The record for Resident E was reviewed on 9/24/15 at 10:55 a.m. Diagnosis included, but was not limited to, hypothyroidism.</p> <p>Resident E's Service Plan, dated 4/25/15, indicated complete supervision and administration of all medications was required.</p> <p>A physician's order, dated 11/2/14, indicated Resident E was to receive levothyroxine (thyroid medication) 25 mcg (micrograms) every a.m.</p> <p>The September, 2015, MAR (Medication Administration Record) indicated the levothyroxine was unavailable for administration on September 1, 16, 20, and 21. The MAR documentation did not indicate levothyroxine was given as prescribed on September 3, 4, 9, 12, 13, 14, 17, 18, 19, 22, and 23.</p> <p>The Nurses Notes, dated 9/17/15 at 6:55 a.m., indicated the pharmacy was contacted regarding the lack of medication supply of levothyroxine. The record indicated the resident's insurance would not pay for additional medication</p>		<p>are available and administered according to physician's orders. On 10/7/15, Nursing staff have received education regarding medication availability with signature required. (See attachment). As a means of ongoing compliance, a quality assurance program will be implemented under the supervision of the Director of Nursing and Quality Assurance RN to monitor medication reordering. The Quality Assurance RN or designee will perform the following systemic changes: Weekly audits concerning medication reordering will be done. Any deficiencies will be corrected on the spot and the findings of these weekly quality assurance audits will be documented and submitted on an ongoing basis to the quality assurance team at the quarterly meetings for further review and corrective action.</p>	

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	<p>until 9/21/15. The record did not indicate the facility secured a supply of medication to ensure no doses were missed and did not indicate the physician was notified of the missed doses.</p> <p>A Nursing Note on 9/18/15 at 6:00 a.m. indicated the pharmacy sent 1 levothyroxine tablet and it was administered.</p> <p>During an interview on 9/24/15 at 11:10 a.m., QMA # 2 indicated medication was ordered when the resident's supply became low and indicated an order date was written on the label so other staff were aware it had been ordered. The QMA indicated she would tell the charge nurse if the medication was not received at the facility.</p> <p>An undated facility policy, titled, "Residence Building Policy for Nursing Care" was provided by the Administrator on 9/24/15 at 9:00 a.m. The policy indicated, "...4. Administering medications and/or treatments as prescribed by the physician shows indication of needing this service or if the physician mandates the same...."</p> <p>An untitled memorandum, dated 8/19/15, was provided by the Administrator on 9/24/15 at 10:40 a.m. The memorandum,</p>			

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R 0297 Bldg. 00	<p>signed and dated by the licensed nursing staff, indicated:</p> <p>"1. Residents must have a supply of all ordered medication at all times. Being out of any medication for even 1 dose is not acceptable.</p> <p>2. Stay proactive in ordering medications in adequate time frames to receive them from the pharmacy, including mail order, before the supply runs out.</p> <p>3. Medications must be obtained from an alternate pharmacy (such as [name of pharmacy]) if supply is running out and a new supply has not arrived. POA must be notified.</p> <p>4. If for any reason a resident's medication is not available, the administrator or DON [Director of Nursing] must be notified...."</p> <p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on record review and interview, the facility failed to ensure arrangements were made with the dispensing pharmacy to ensure levothyroxine (thyroid</p>	R 0297	Resident E had had her Levothyroxine since September 21, 2015 without any interruptions. No other residents were affected. It is the policy of	10/13/2015

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	<p>medication) was available for administration for 1 of 3 residents reviewed for medication administration. (Resident E)</p> <p>Finding includes:</p> <p>The record for Resident E was reviewed on 9/24/15 at 10:55 a.m. Diagnosis included, but was not limited to, hypothyroidism.</p> <p>Resident E's Service Plan, dated 4/25/15, indicated complete supervision and administration of all medications was required.</p> <p>A physician's order, dated 11/2/14, indicated Resident E was to receive levothyroxine (thyroid medication) 25 mcg (micrograms) every a.m.</p> <p>The September, 2015, MAR (Medication Administration Record) indicated the levothyroxine was unavailable for administration on September 1, 16, 20, and 21. The MAR documentation did not indicate levothyroxine was given as prescribed on September 3, 4, 9, 12, 13, 14, 17, 18, 19, 22, and 23.</p> <p>The Nurses Notes, dated 9/17/15 at 6:55 a.m., indicated the pharmacy was contacted regarding the lack of</p>		<p>this facility to ensure medications are available and administered according to physician's orders. On 10/7/15, Nursing staff have received education regarding medication administration with signature required. (See attachment). As a means of ongoing compliance, a quality assurance program will be implemented under the supervision of the Director of Nursing and Quality Assurance RN to monitor medication reordering. The Quality Assurance RN or designee will perform the following systemic changes: Weekly audits concerning medication reordering will be done. Any deficiencies will be corrected on the spot and the findings of these weekly quality assurance audits will be documented and submitted on an ongoing basis to the quality assurance team at the quarterly meetings for further review and corrective action.</p>		

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	<p>medication supply of levothyroxine. The record indicated the resident's insurance would not pay for additional medication until 9/21/15. The record did not indicate the facility secured a supply of medication to ensure no doses were missed and did not indicate the physician was notified of the missed doses.</p> <p>A Nursing Note on 9/18/15 at 6:00 a.m. indicated the pharmacy sent 1 levothyroxine tablet and it was administered.</p> <p>During an interview on 9/24/15 at 11:10 a.m., QMA # 2 indicated medication was ordered when the resident's supply became low and indicated an order date was written on the label so other staff were aware it had been ordered. The QMA indicated she would tell the charge nurse if the medication was not received at the facility.</p> <p>An undated facility policy, titled, "Residence Building Policy for Nursing Care" was provided by the Administrator on 9/24/15 at 9:00 a.m. The policy indicated, "...4. Administering medications and/or treatments as prescribed by the physician shows indication of needing this service or if the physician mandates the same...."</p>			

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