STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155491	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN CENTERS FOR REHABILITATION AND HEALTHCARE	1029 E 5TH ST CONNERSVILLE, IN 47331

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F0000	This visit was for the Investigation of Complaint IN00102817. Complaint IN00102817 - Substantiated. Federal/state deficiencies related to the allegation are cited at F332. Survey dates: February 11 and 12, 2012 Facility number: 000316 Provider number: 155491 AIM number: 100286370 Survey team: Barbara Gray RN TC Sharon Lasher RN Census bed type: SNF/NF: 111 Total: 111 Census payor type: Medicare: 15 Medicaid: 62 Other: 34 Total: 111 Sample: 5 This deficiency reflects state findings cited in accordance with 410 IAC 16.2.	F0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	

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 2/16/12 by Suzanne Williams, RN			

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F0332 SS=E	The facility must ensure that it is free of medication error rates of five percent or greater.			
	Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% for 5 of 24 residents observed receiving medications (Residents # H, #I, #J, #K, and #L). Sixteen errors in medication administration were observed during 78 opportunities for error in medication administration. This resulted in a medication error rate of 20.5%. Findings include: 1.) During an observation of medication pass on 2/11/12 at 10:15 p.m. staff LPN #1 prepared and gave Resident #H's Lantus insulin injection, ordered for 9:00 p.m. The record of Resident #H was reviewed on 2/12/12 at 1:00 a.m. Resident #H's physician's recapitulation orders dated 2/12, indicated "Lantus (long acting insulin given once a day) at 9:00 p.m., inject 15 units (unit of measurement for the amount of a substance, based on biological activity or effect) sub-q (injection just under the skin), every bedtime (scheduled for 9 p.m.). 2.) During an observation of medication	F0332	It is the policy of Lincoln Care Centers to comply with regulatory requirement free of medication error rate less 5%. 1.MD was notified prior to late administration and gave order "may administer up to one hour late". No adverse effects were noted to the resident. 2.Quality Assurance rounding was conducted within the facility to visualize no other areas of concern identified as related to the facility failing to administer as ordered for current residents. 3.Current licensed nursing staff was educated on the facility policy and procedure for medication administration as to provide the proper administration as ordered by the physician for current residents. DON/ADON or designee will conduct QA monitor for medication administration 3 x weekly for 4 weeks, then weekly x one month then monthly. 4.Results of the QA monitoring will be reported the Risk Management /Quality Improvement Committee monthly for continued compliance and/or revision. 5.Completion date 3/6/12.	03/06/2012

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	pass on 2/11/12 at 10:20 p.m., staff LPN #1 checked resident #I's blood sugar. Resident #I's blood sugar was 327 and staff LPN #1 prepared 7 units of Humalog insulin and 50 units of Lantus insulin and administered the insulin to Resident #I. Staff LPN #1 also gave Resident #I Ativan and Oyster shell calcium by mouth. Staff LPN #1 also administered Systane and Refresh eye drops. The record of Resident #I was reviewed on 2/12/12 at 12:54 a.m. Resident #I's physician's recapitulation orders dated, 2/12, indicated the following: - Humalog insulin at 9:00 p.m.. inject sub-q, 7 units per sliding scale for blood sugar 301-350 - Ativan (anxiety) 0.5 mg tablet, by mouth, 2 times a day - Lantus insulin at 9:00 p.m., inject 50 units sub-q - Oyster shell calcium, 500 mg, by mouth, 2 times a day - Systane 0.3-0.4% eye drops, instill 1 drop into each eye, 4 times a day for dry eyes - Refresh liquid gel 1 drop, both eyes, 2 times a day. The time indicated on Resident #I's physician's recapitulation order indicated 9:00 p.m.			

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	3.) During an observation of medication pass on 2/11/12 at 10:50 p.m., staff LPN #1 gave Resident #J the medications Calcium with vitamin D and Coreg, by mouth, and administered Alphacan P eye drops. The record of Resident #J was reviewed on 2/12/12 at 1:05 a.m. Resident #J's physician's recapitulation orders dated, 2/12, indicated the following: - Alphacan P, 0.1% drops, instill 1 drop into each eye, 2 times a day, for glaucoma - Calcium 600 mg plus vitamin D tablet, by mouth, 2 times a day, for supplement - Coreg 6.25 mg, give by mouth, 2 times a day, for congestive heart failure. The times indicated on Resident #J's physician's recapitulation order indicated 9:00 p.m. 4.) During observation of medication pass on 2/11/12 at 11:00 p.m., staff LPN #1 gave resident #K Lantus insulin, ordered for 9:00 p.m., sub-q. The record of Resident #K was reviewed on 2/12/12 at 12:55 a.m. Resident #K's physician's recapitulation orders dated, 2/12, indicated Lantus insulin, 4 units sub-q, every bedtime. The time indicated on Resident #K's physician's recapitulation orders indicated			

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	9:00 p.m. 5.) During observation of medication pass on 2/11/12 at 11:10 p.m., staff LPN #1 administered Resident #L's nebulizer treatment. The record of Resident #L was reviewed on 2/12/12 at 1:10 a.m. Resident #L's physician's recapitulation orders dated 2/12, indicated "Duoneb, Nebulizer treatment, 0.5-3 (2.5) mg/3ml, inhale 3 ml via nebulizer (breathing treatment), 4 times a day." Resident #L's physician's recapitulation orders indicated 9:00 p.m. During interview with staff LPN #1 on 2/11/12 at 11:05 p.m., indicated with the amount of medications to give, there was no way the medication pass could be completed without being late. Staff LPN #1 indicated it was much later than 11:00 p.m. most nights when the 9:00 p.m. medication pass was complete, but tonight was different with 18 residents to administer medication to instead of 28 residents. Staff LPN #1 indicated most nights at 9:00 p.m., the 800 hall is split between the nurse on the 700 hall and the nurse on the 900 hall, but tonight the residents on the 900 hall were the only residents on staff LPN #1's medication pass.			

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	During interview with staff QMA #2 on 2/11/12 at 11:15 p.m.,she indicated she had just completed her 9:00 p.m. medication pass in the 800 hall of the West building. Staff QMA #2 indicated she had been scheduled to pass medications until 9:00 p.m., then scheduled to work as a CNA on the floor after 9:00 p.m. Staff QMA #2 indicated the facility had requested another CNA to come in, and so she (QMA #2) passed medication on the 800 hall of the West building until 11:00 p.m. She indicated the nurses scheduled on the 700 hall and the 900 hall of the West building usually split the medication pass on the 800 hall of the West building, but she had passed the medication on the 800 hall in the West building tonight. A document titled "Medication Administration Times" provided by the Administrator on 2/12/12 at 12:05 a.m., dated, May, 2010 and indicated by the Administrator to be the most current policy, indicated "Procedure, facility should commence medication administration within sixty minutes before the designated times of administration and should be completed by sixty minutes after the designated times of administration. Facility's medication administration			

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	policy to determine whether certain medications require different administration times. Additional guidance can be found regarding medication administration schedules in Appendix 17: "Facility Medication Administration Schedule." During interview with the Administrator on 2/12/12 at 12:45 a.m., she indicated she does not have a copy of the Appendix 17: "Facility Medication Administration Schedule." The times on the MAR (Medication Administration Record) indicate what time the medications are to be given and the nurses have an hour before that time and an hour after that time to give the medication, but she does not have anything that states the times medications are to be given. The Administrator stated "it is just the times we have been using for years." This federal tag relates to complaint IN00102817. 3.1-25(b)(9)			