

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 08/07/2013
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NAME OF PROVIDER OR SUPPLIER BEARDSLEY HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 27833 CR 24 ELKHART, IN 46517
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R000000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: August 5-7, 2013</p> <p>Facility number: 004353 Provider number: 004353 AIM number: N/A</p> <p>Survey team: Deb Kammeyer, RN, TC Lora Swanson, RN Julie Wagoner, RN</p> <p>Census bed type: Residential : 22</p> <p>Census payor type: Private: 22</p> <p>Sample: 10</p> <p>These deficiencies are cited in accordance with 410 IAC 16.2</p> <p>Quality Review completed on August 14, 2013, by Brenda Meredith, R.N.</p>	R000000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.</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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R000091	<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.</p> <p>Based on observation, record review, and interview, the facility failed to establish a policy regarding swallowing precautions. This affected 1 of 7 residents who had a physician's order requiring swallowing precautions. (Resident #4)</p> <p>Finding includes:</p> <p>!. During the initial tour of the facility, conducted on 08/05/13 between 10:30 A.M. - 11:00 A.M., LPN #3 indicated Resident #4 had been admitted to the facility the previous week, received Hospice care, and required nectar thickened liquids and a pureed diet.</p> <p>The clinical record for Resident #4 was reviewed on 08/05/13. The clinical record indicated Resident #4 was admitted to the facility on 08/02/13 with diagnosis, including but</p>	R000091	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #4 no longer resides at the community. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director and/or Designee reviewed current physician orders for accuracy and completion. No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? Staff were re-educated as to the Indiana state regulation R 091 410 IAC 16.2-5-1.3(h) (1-4) Administration and Management and our policy and procedure regarding obtaining physician orders. Staff was re-educated to the fact that we do not accept blanket orders from physicians such as "swallow precautions",</p>	09/15/2013			

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	<p>not limited to: ARF (adult respiratory failure), anemia, malnutrition, and bone marrow dysplasia.</p> <p>Physician's orders, dated 08/02/13 and 08/05/13, indicated the resident was to receive "1. Nectar thick liquids. 2. Continue swallowing precautions."</p> <p>The resident was observed on 08/05/13 at 11:20 A.M., lying in his bed asleep. A cup of red, pudding thick liquid and a spoon were noted on the overbed table beside his bed. On 08/05/13 at 12:35 P.M., a nursing staff member was noted to feed the resident his lunch tray. The resident was noted to have received water, thickened to a pudding consistency and pureed food.</p> <p>On 08/06/13 at 8:45 A.M., the resident was observed in his room in bed. The resident's breakfast tray was noted on the kitchenette counter. The resident's neighbor was in the room and indicated she had fed the resident some of his oatmeal. The neighbor indicated the tray had one large glass of cranberry juice on it. The red colored juice was noted to be pudding thick. The neighbor then opened the small refrigerator in the resident's room and two glasses of</p>		<p>and that we must contact physician for clarification orders with specific physician driven interventions. Staff and outside providers were re-educated to policy and procedure that we do not use thick-it and only supply pre-thickened liquids as to ensure proper consistency for residents who require thickened liquids by physician orders. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will conduct a random weekly review of physician orders to ensure continued compliance with the above referenced regulation for a period of six months. RD/WD and/or designee will monitor any resident with orders for thickened liquids to ensure we have pre-thickened liquids on hand and no thick-it is being used. The community will determine the need for an ongoing monitoring plan during the team QA review at the end of six months. Findings suggestive of compliance will result in cessation of the monitoring plan. New orders will also be reviewed by the regional team during their quarterly visits to ensure sustained compliance. By what date will the systemic changes be completed? September 15, 2013</p>				

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	<p>thickened water and coke were observed. Both liquids were hardened and had spoons sticking up out of them.</p> <p>On 08/07/13 at 9:38 A.M., Resident #4 was observed in his bed asleep. There was a full glass of red, nectar thickened liquid on his overbed table and a partially eaten breakfast tray on the kitchenette counter. The resident's neighbor was in the room and indicated she had fed the resident his breakfast.</p> <p>Interview with the Regional nurse consultant, RN #4, at 08/07/13 at 9:50 A.M., indicated the facility had no policy for swallow precautions outside of just following the physician's orders.</p>						

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R000214	<p>410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on record review and interview the facility failed to complete a pre-admission evaluation upon admission in 1 of 7 residents reviewed for pre-admission evaluations. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record of Resident #2 was reviewed on 8-6-13 at 1:20 P.M. The resident's diagnoses included, but were not limited to breast cancer, liver cancer, hypertension and edema. The resident's admission date was 9-14-12.</p> <p>The clinical record contained no pre-admission evaluation. A nursing note dated 9-14-12 at 4:00 P.M., indicated the resident had "...visited prior to admission...." A review of form titled "Resident Vital Signs" indicated resident was first weighed in the facility on 10-6-12.</p> <p>A review of (name) Hospice Services,</p>	R000214	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>Resident #2 no longer resides at the community.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The Wellness Director and/or Designee reviewed current resident records to ensure appropriate assessments were completed with no other residents found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>Staff were re-educated to the Indiana state regulation 410 IAC</p>	09/15/2013			

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	<p>dated 9-17-13, indicated "...chart not at facility - only MAR [medication administration record] - per facility staff - pts [patient's] chart at former ALF [assisted living facility]...."</p> <p>On 7-7-13 at 1:40 P.M., an interview was conducted with RN #4. The RN indicated that he was instructed that since the resident came from an unlicensed "sister facility" the pre-admission and admission assessments that would include a weight weren't required.</p> <p>On 7-7-13 at 2:00 P.M., a policy titled "Resident Assessments" indicated "...As part of the pre-move process, and on an on-going basis, residents will be assessed using a variety to assessment tools. Another policy titled "Nursing Assessments" indicated "...Each resident must have an initial Nursing Comprehensive Evaluation completed by the Wellness Director within seven days of his/her move-in date unless dictated otherwise by state regulations...."</p>		<p>16.2-5-2(a) and our policy and procedures regarding the service level assessment, pre-admission assessment and the move in process.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Wellness Director and/or Designee will conduct a random weekly review of resident records to ensure continued compliance with assessment and evaluations for current and future residents for a period of six months. The community will determine the need for an ongoing monitoring plan during the team QA review at the end of six months. Findings suggestive of compliance will result in cessation of the monitoring plan. The Regional team will also review new move-in paperwork upon quarterly visits to ensure sustained compliance.</p> <p>By what date will the systemic changes be completed?</p> <p>September 15, 2013</p>				

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R000240	<p>410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure 1 of 7 residents received personal care and assistance with swallowing needs. (Resident #4)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 08/05/13 between 10:30 A.M. - 11:00 A.M., LPN #3 indicated Resident #4 had been admitted to the facility the previous week, received Hospice care, and required nectar thickened liquids and a pureed diet and had been running an elevated temperature.</p> <p>The clinical record for Resident #4 was reviewed on 08/05/13. The clinical record indicated Resident #4 was admitted to the facility on 08/02/13 with diagnosis, including but not limited to, ARF (adult respiratory failure), anemia, malnutrition, and bone marrow dysplasia.</p> <p>Physician's orders, dated 08/02/13 and 08/05/13, indicated the resident was to receive "1. Nectar thick</p>	R000240	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? Resident #4 no longer resides at the community. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Wellness Director and/or Designee reviewed current physician orders for accuracy and completion. No other residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? Staff were re-educated to the Indianan state regulation R 240 410 IAC 16.2-5-4(d) Health Services and our policy and procedure concerning physician orders. Staff was re-educated to the fact that we do not accept blanket orders from physicians such as "swallow precautions", and that we must contact physician for clarification orders with specific physician driven interventions. Staff and outside providers were re-educated to policy and procedure that we do not use thick-it and only supply</p>	09/15/2013			

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	<p>liquids. 2.. Continue swallowing precautions."</p> <p>The resident was observed on 08/05/13 at 11:20 A.M., lying in his bed asleep. A cup of red, pudding thick liquid and a spoon were noted on the overbed table beside his bed. On 08/05/13 at 12:35 P.M., a nursing staff member was noted to feed the resident his lunch tray. The resident was noted to have received water, thickened to a pudding consistency and pureed food.</p> <p>On 08/06/13 at 8:45 A.M., the resident was observed in his room in bed. The resident's breakfast tray was noted on the kitchenette counter. The resident's neighbor was in the room and indicated she had fed the resident some of his oatmeal. The neighbor indicated the tray only had one large glass of cranberry juice. She indicated the resident liked coffee and ice water in the past but was only provided the cranberry juice. The red colored juice was noted to be pudding thick. The neighbor then opened the small refrigerator in the resident's room and two glasses of thickened water and coke were observed. Both liquids were hardened and had spoons sticking up out of them.</p>		<p>pre-thickened liquids as to ensure proper consistency for residents who require thickened liquids by physician orders. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/or Designee will conduct a random weekly review of physician orders to ensure continued compliance with the above referenced regulation for a period of six months. RD/WD and/or designee will monitor any resident with orders for thickened liquids to ensure we have pre-thickened liquids on hand and no thick-it is being used. The community will determine the need for an ongoing monitoring plan during the team QA review at the end of six months. Findings suggestive of compliance will result in cessation of the monitoring plan. New orders will also be reviewed by the regional team during their quarterly visits to ensure sustained compliance.</p> <p>By what date will the systemic changes be completed? September 15, 2013</p>	

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	<p>On 08/07/13 at 9:38 A.M., Resident #4 was observed in his bed asleep. There was a full glass of red, nectar thickened liquid on his overbed table and a partially eaten breakfast tray on the kitchenette counter. The resident's neighbor was noted in the room. She indicated she had fed the resident his breakfast.</p> <p>Interview with the Regional nurse consultant, RN #4, on 08/07/13 at 08/07/13 at 9:50 A.M. indicated the facility had no policy for swallow precautions outside of just following the physician's orders.</p>			

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R000241	<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, record review, and interviews, the facility failed to ensure the service plans regarding medication administration needs for 1 of 7 residents reviewed and 2 of 5 residents observed receiving medications was followed and/or accurate. (Residents #5, 9, and 10)</p> <p>Findings include:</p> <p>1. During observation of a medication administration pass, conducted on 08/06/13 at 11:20 A.M. for Resident #9, a bedside tray of over the counter and prescription medications were noted in the resident's room. The medications included liquid and tablet stool softeners, antacid tablets, nicotine gum, Percocet pain medication, an inhaler and administration chamber, and two types of eye drop. Interview with LPN #3, on 08/06/13 at 11:20 A.M., indicated Resident #9 had an order for the Percocet (a narcotic pain medication) and "over the counter"</p>	R000241	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>Resident #5 and # 9 and/or their responsible party if applicable were also educated to our policy and procedures concerning physician orders, resident self-medication administration, and storage of medications. A new self-medication administration assessment was completed for Resident #5 and #9 with orders obtained as to each resident's ability to self-administer their medication and as to the correct medication as prescribed by the physician.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The Wellness Director and/or Designee reviewed current</p>	09/15/2013			

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	<p>medications to be kept at bedside for nighttime and as needed use by the resident.</p> <p>At approximately 11:15 A.M. on 08/06/13, a gentleman, identified by LPN #3 as the psychiatrist, had spoken with LPN #3 regarding his concern with Resident #9's dementia. He mentioned the resident could not remember if she had gotten up and eaten her breakfast that particular morning. He indicated he had set her up with a particular program on her computer to enhance Resident #9's memory and mind and he asked LPN #3 to encourage Resident #9 to use the program.</p> <p>On 08/07/13 at 9:00 A.M., Resident #9 was observed sitting up awake in her bed. The bedside tray of over the counter medications was noted, however, the card containing the narcotic pain medication, Percocet, and the nicotine gum were not noted on the tray. The tray did contain a bottle of stool softener tablets, a bottle of liquid stool softer, a bottle of anti-diarrhea medication, two bottles of eye drops, an inhaler vial connected to an administration chamber, and a large 1/2 full bottle of antacid tablets. A housekeeper, Employee #11 was noted in the room</p>		<p>physician orders and resident rooms to ensure medications orders were accurate. Residents whom self-administer their medication were reviewed and determined to be capable of safe storage and administration in collaboration with their physician.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>Staff were re-educated to our policy and procedures regarding physician orders, resident self-administration of medication, medication storage, and staff administration.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>Weekly random checks of resident rooms will be conducted by WD, RD, and/or Designee to ensure continued compliance for a period of six months. The community will determine the need for an ongoing monitoring plan during the team QA review at the end of six months. Findings suggestive of compliance will result in cessation of the monitoring plan. The regional</p>				

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	<p>by the kitchenette removing a bottle of arthritis and vitamin supplements from the packaging.</p> <p>Resident #9 was queried regarding the medications name, use, and dose and could only correctly identify the name and use of the stool softeners. During the interview, Employee #11 kept trying to answer for Resident #9. Employee #11 indicated she distributed the over the counter and supplemental medications to Resident #9. She confirmed she was employed as the facility housekeeper, but indicated she was a "personal care giver" for Resident #9.</p> <p>The clinical record for Resident #9 was reviewed on 08/07/13 at 10:45 A.M. Resident #9 had diagnoses, including but not limited to: congestive heart failure, atrial fibrillation, hypertension, anxiety, depression, chronic pain, and anemia. The most recent needs assessment and service plan, completed on 05/06/13, indicated the resident needed the facility to administer or supervise self-administration her medications. There was no place on the needs assessment which indicated the resident was capable of self administering over the counter</p>		<p>team will review self-medication administration assessments, physician orders for self-administration and assure that weekly checks of rooms have been completed upon quarterly visits to ensure sustained compliance</p> <p>By what date will the systemic changes be completed?</p> <p>September 15, 2013</p>				

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	<p>medications or prescription medications.</p> <p>The current physician's orders for July 2013 indicated the facility administered the resident's routine medications, including routine stool softeners, routine pain medications, including pain patches, and a routine iron supplements and multivitamin. The percocet pain medication was ordered to be given 4 times a day at 8 A.M., 12 P.M., 6 P.M., and 10 P.M.. Nicotine Polacrilex gum, Xanax (an anti-anxiety medication), Combivent inhaler, guaifenesin (cold medication), and polyethylene glycol (stool softener) powder, and albuterol inhaler were all ordered as needed.</p> <p>There was a specific order indicating the 10:00 P.M. Percocet could be left at the bedside for the resident "to take during the noc (night) when needed."</p> <p>The Mediation Self Administration/Diabetes Self Management Assessment, completed on 01/02/13, for Resident #9 indicated she could distinguish and match colors, and shapes, tell time and when a prescription was due, read a prescription label, knew purpose of medications, could</p>			

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	<p>remove medication from card or bottle, and could maintain safe organization and storage of medications as required by policy and state regulations and could use a metered dose inhaler properly. A check list reviewing the self administration of medications assessment, completed on 07/15/13, indicated there had been no change with the resident's ability to self administer her medications.</p> <p>Interview with the Regional nurse consultant, RN #3, on 08/07/13 at 11:45 A.M., indicated the housekeeper, Employee #11 used to be the Power of Attorney and "roommate" of Resident #9 prior to moving to the facility. He indicated it was a struggle to get Employee #11 to accept her new role as she still tried to dictate care needs for Resident #9. There was no comment as to why the facility was only administering part of the resident's medications and why the needs assessment did not indicate the resident's needs correctly. In addition, there was no indication as to when the resident had started to display dementia type features. Finally, the 01/02/13 self administration form did not indicate which medications the resident was</p>			

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	<p>able to safely and correctly identify.</p> <p>2. During the initial tour of the facility, conducted on 08/05/13 at 10:30 A.M., indicated Resident #10 had Alzheimer's dementia and was not interviewable.</p> <p>Resident #10 was observed on 08/05/13 at 11:20 A.M., ambulating in the hallway with her walker. The resident was noted to be distressed and indicated she did not know how to "get out of here." She indicated her room number but when cued to her room indicated "I can't go in there it won't do me a bit of good, I need to get out of here."</p> <p>During observation of a medication administration pass, conducted on 08/07/13 at 8:45 A.M., Resident #10 was observed in her room. A bottle of Tylenol and Aleve were noted on the kitchenette counter along with a large white bottle.</p> <p>Interview with Resident #10, on 08/07/13 at 9:30 A.M., indicated the large white bottle was cat medication. She correctly identified the name and use for the Tylenol and the Aleve but could not verbalize how many tablets she should take at one time or how many tablets she could safely take in</p>			

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	<p>a 24 hour period. The resident stated "---, I don't think I've taken either of those for awhile. I don't know (referring to how many she could take at one time or in a 24 hour period) I guess at least one."</p> <p>The clinical record for Resident #10 was reviewed on 08/07/13 at 11:00 A.M. Resident #10 was admitted to the facility on 03/14/13 with diagnosis, including but not limited to, dementia. The physician's orders on admission indicated an order the the resident could keep medications in her apartment and self-administer and Resident was capable of maintaining OTC (over the counter) medications in her own apartment for PRN (as needed) use.</p> <p>The most recent needs assessment and negotiated service plan summary for Resident #10, completed on 04/22/13, indicated the facility was going to administer medications to the resident.</p> <p>The initial Medication Self Administration/Diabetes Self Management Assessment, completed for Resident #10 on 03/30/13, indicated the resident was able to manage her own medications except was unable to state and report side</p>			

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	<p>effects. However, the monthly Review Log for Self Administration of Medications form, indicated the last review had been completed on 04/10/13 and indicated the resident was not able to self medicate.</p> <p>3. During the initial tour of the facility, conducted on 08/05/13 at 10:30 A.M. with LPN #3, Resident #5 was identified as confused and required total staff assistance for Activities of Daily Living.</p> <p>On 08/07/13 at 10:20 A.M., Resident #5 was observed in her room, in a chair, looking at a magazine. The resident gave permission to look in her kitchenette cupboards and an unopened bottle of cold and flu medication and a 1/2 full bottle of folic acid were noted. The resident was asked to identify each medication. She could not name the medications, she spelled the cold and flu brand name but could not state the name. She could not identify the use or doses of either medication. She indicated she "takes a few" of the folic acid tablets daily. She just answered "Mmm Hmm" when asked about the cold and flu medications.</p> <p>The most recent needs Assessment and Negotiated Service Plan</p>			

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	<p>Summary for Resident #5, completed on 06/21/13, indicated the facility was going to administer medications to the resident.</p> <p>Interview with the Regional Nurse Consultant, RN #1, on 08/07/13 at 11:00 A.M. indicated Resident #5's daughter must have brought medications/supplements into Resident #5's apartment. He indicated the resident was unable to administer her own medications.</p>			

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R000243	<p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview the facility failed to document medication administration in 1 of 7 residents reviewed for record review. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record of Resident #2 was reviewed on 8-6-13 at 1:20 P.M. The resident's diagnoses included, but were not limited to breast cancer, liver cancer, hypertension and edema. The resident's admission date was 9-14-12.</p> <p>On 8-6-13 at 1:35 P.M. a review of the medication administration record (MAR) indicated documentation of medication administration started on 9-19-12.</p> <p>On 8-6-13 at 1:45 P.M., an interview with RN #4 indicated the resident was transferred to the facility with a "sister facilities MAR," an unlicensed facility.</p>	R000243	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>Resident #2 no longer resides at the community.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The Wellness Director and/or Designee reviewed current resident records to ensure physician order were obtained and accurate with no other residents found to be affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>Staff were re-educated to our</p>	09/15/2013			

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	<p>He further indicated that all medications that were administered to the resident from 9-14-12 thru 9-18-12 were documented on that MAR until a new MAR was received on 9-19-13. He was unable to locate the old MAR to verify medication name, time given, dosage and nurse administering the medications from 9-14-12 thru 9-18-12.</p> <p>On 8-7-13 at 9:00 A.M. a review of a policy titled "Physician Orders" indicated "...Orders for medications and treatments must be transcribed to the MAR...."</p>		<p>policy and procedures concerning physician orders, "the six rights" of medication administration, as well as the above referenced regulation. The Wellness Director and/r Designee will be responsible to ensure the below monitoring plan is implemented and compliance is maintained.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Wellness Director and/or Designee will conduct a weekly random review of resident orders against the Medication Administration Record to ensure orders are transcribed correctly for a period of six months. The community will determine the need for an ongoing monitoring plan during the team QA review at the end of six months. Findings suggestive of compliance will result in cessation of the monitoring plan. The regional team will review all new move-in paperwork upon quarterly visits to ensure sustained compliance.</p> <p>By what date will the systemic changes be completed?</p> <p>9/15/2013</p>		

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R000246	<p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record review and interview, the facility failed to ensure that a Qualified Medication Aide (QMA) documented in the nurses notes the time and date of contact with a nurse regarding the authorization to administer an as needed (PRN) medication. The facility also failed to ensure that a resident's record was cosigned by the licensed nurse who gave permission for the prn medication to be administered. This had the potential to affect 1 of 7 resident's reviewed for medication authorization. (Resident #7)</p> <p>Findings include:</p> <p>On 8/7/13 at 10:15 A.M., record review indicated Resident #7's diagnosis included but were not limited to: dementia, Alzheimer's with behavioral disturbance, diabetes type II, peripheral vascular disease and</p>	R000246	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>Resident #7 no longer resides at the community.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>The Wellness Director and/or Designee reviewed the Medication Administration Record with re-education provided to appropriate staff as to QMA scope of practice when administering PRN medication.</p> <p>What measures will be put into place or what systemic</p>	09/15/2013			

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	<p>artery bypass graft.</p> <p>Review of the nurse's medication notes indicated that QMA #6 administered meds on the following dates: on 1/30/13 at 3:15 P.M., Xanasc [sic] 0.25 mg [milligrams] 1/2 tab PO (orally) increased agitation, 4:15 P.M. effective ok per initials. On 2/1/13 at 5:00 P.M., Ativan 0.5 mg PO aggitation [sic], 6:00 P.M. effective ok per WD. On 2/9/13 at 8:00 P.M., Ativan 0.5 mg 1 PO increased agitation, 9 P.M. effective ok per initials. On 2/10/13 at 5:00 P.M., Ativan 0.5 mg 1 PO increased agitation, 6 P.M. effective ok per initials. On 2/12/13 at 8:00 P.M., Tylenol 500/25 mg 1 PO complaints of (c/o) general pain, 9 P.M. effective ok per initials. On 2/13/13 at 8:00 P.M., Tylenol 500/25 mg 1 PO c/o general pain, 9:00 P.M. effective ok per initials. On 2/15/13 at 8:00 P.M., Tylenol 1 PO c/o general pain, 9:00 P.M. effective ok per initials. On 4/2/13 at 4:30 P.M., Morphine Sulfate 0.25 ml restlessness, 5:30 P.M. effective ok per LPN (licensed practical nurse). On 4/2/13 at 9:00 P.M., Morphine Sulfate 0.25 ml restlessness, 10:00 P.M. effective ok per LPN. Further review of the nurses's medication notes indicated no co-signatures were obtained from</p>		<p>changes will the facility make to ensure that the deficient practice does not recur?</p> <p>A Wellness Director, RN, has been hired and is currently in place. Staff were re-educated to the QMA scope of practice regarding PRN medication administration. The Wellness Director and/or Designee will be responsible to ensure continued compliance with the QMA scope of practice.</p> <p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Wellness Director and/or Designee will conduct a weekly random review the Medication Administration Record to ensure continued compliance with the QMA scope of practice pertaining to PRN medication administration for a period of six months. The community will determine the need for an ongoing monitoring plan during the team QA review at the end of six months. Findings suggestive of compliance will result in cessation of the monitoring plan. The regional team will also review resident MARs and service notes for any administration of PRNs by a QMA to ensure continued compliance with 410 IAC 16.2-5-4(e)(6) to</p>				

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	<p>a nurse for the above medication dates.</p> <p>Review of the resident service notes for the above dates indicated no record of symptoms or that the licensed nurse was contacted for permission to administer the medication.</p> <p>On 8/7/13 at 11:00 A.M., an interview with Employee #4 indicated that it is the facilities policy when a QMA administers a prn medication it should be documented in the resident services note and the med should be cosigned by a nurse and he is not sure why that was not done.</p> <p>On 8/7/13 at 11:15 A.M., review of the "Proposed Rule Article 2. Qualified Medication Aides" received from Employee #4 indicated "...Scope of practice...Administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication and time symptoms occurred. (B) Document in the resident record that the facility's licensed nurse was contacted,</p>		<p>ensure sustained compliance.</p> <p>By what date will the systemic changes be completed?</p> <p>September 15, 2013</p>				

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	<p>symptoms were described, and the permission was granted to administer the medication, including the time of contact. (C) Obtain permission to administer the medication each time the symptoms occur in the resident. (D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty...."</p>			

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R000352	<p>410 IAC 16.2-5-8.1(e)(1-4) Clinical Records - Noncompliance (e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes.</p> <p>Based on record review and interview, the facility failed to transcribe a medication administration record at admission for 1 of 7 residents reviewed for record review. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record of Resident #2 was reviewed on 8-6-13 at 1:20 P.M. The resident's diagnoses included, but were not limited to breast cancer, liver cancer, hypertension and edema. The resident's admission date was 9-14-12.</p> <p>On 8-7-13 at 1:35 P.M. a review of the medication administration record (MAR) indicated documentation of medication administration started on 9-19-12.</p> <p>On 8-7-13 at 1:45 P.M., an interview with RN #4 indicated the resident was transferred to the facility with a "sister facilities MAR", an unlicensed facility.</p>	R000352	<p>What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?</p> <p>Resident #2 no longer resides at the community.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>A review was conducted of current resident records with no other residents found affected.</p> <p>What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?</p> <p>Staff were re-educated to our policy and procedures regarding the move in process, as well as obtaining physician order, and the "six rights of medication administration".</p>	09/15/2013			

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	<p>He further indicated that all medications that were administered to the resident from 9-14-12 thru 9-18-12 were documented on that MAR until a new MAR was received on 9-19-13 from the pharmacy. He was unable to located the old MAR to verify medications given 9-14-12 thru 9-18-12.</p> <p>On 8-7-13 at 9:00 A.M. a review of a policy titled "Physician Orders" indicated "...Orders for medications and treatments must be transcribed to the MAR...."</p>		<p>How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The Wellness Director and/or Designee will conduct a random weekly review of physician orders to ensure continued compliance with the above referenced regulation for a period of six months. The community will determine the need for an ongoing monitoring plan during the team QA review at the end of six months. Findings suggestive of compliance will result in cessation of the monitoring plan. New orders will also be reviewed by the regional team during their quarterly visits to ensure sustained compliance.</p> <p>By what date will the systemic changes be completed?</p> <p>September 15, 2013</p>				