

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155443	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/02/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF MUNCIE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 CHATEAU DR MUNCIE, IN 47303
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F000000	<p>This visit was for the Investigation of Complaint IN00158962.</p> <p>Complaint IN00158962 - Substantiated, Federal/State deficiencies related to the allegations are cited at F386, F387, F309 and F514.</p> <p>Survey dates: December 1 and 2, 2014</p> <p>Facility Number: 000310 Provider Number: 155443 AIM number: 100288970</p> <p>Surveyor: Betty Retherford, RN</p> <p>Census bed type: SNF/NF: 59 Total: 59</p> <p>Census payor type: Medicare: 8 Medicaid: 46 Other: 5 Total: 59</p> <p>Sample: 3</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2-3.1.</p>	F000000		

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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F000309 SS=D	<p>Quality review completed by Debora Barth, RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident received her pain medication in a timely manner in accordance with physician's orders for 1 of 3 residents reviewed for pain management in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 12/1/14 at 11:20 a.m. Diagnoses for the resident included, but were not limited to; joint pain, multiple sites; degenerative arthritis, secondary Parkinson; and dementia with behavioral disturbances.</p> <p>A quarterly Minimum Data Set assessment, dated 9/24/14, indicated the</p>	F000309	F 309 Resident B has had a pain assessment completed to evaluate her pain. Resident B's pain is being managed in a timely manner per non pharmacological and pharmacological interventions as per physician's orders to her satisfaction and she is being kept comfortable. Residents have had their records reviewed to ensure that they have had a pain assessment within the last quarter and that they have appropriate orders and medications in place to manage their pain. Their care plans have been updated as necessary. A monthly narcotic report will be generated by the pharmacy by the 5th of each month. This report will be reviewed by the DON/Designee. At that time any necessary requests will be made to the physician for any	12/26/2014

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	<p>resident had problems with intermittent pain at a moderate level and received both routine and as needed pain medication.</p> <p>A health care plan problem, last reviewed on 11/24/14, indicated the resident had problems with chronic pain. One of the approaches for this problem was to give "meds per order".</p> <p>A recapitulation (recap) of physician's orders for Resident #B, dated 9/9/14, indicated the resident had an order for Hydrocodone/APAP [Norco] 5/325 mg (milligrams) two tablets by mouth three times daily. The times noted for the medication to be given were 6 a.m., 2 p.m., and 10 p.m.</p> <p>A nursing note, dated 11/1/14 at 8:21 p.m., indicated the nurse on duty had called a family member of Resident #B and notified the family member that a new order had been received from a doctor "on call" for [name of former Medical Director]. The note indicated the family member notified the nurse on duty that the former Medical Director was not the resident's physician and asked the nurse to call the resident's personal physician related to the need for an order.</p>		<p>needed written hard scripts with 2 or less refills on hand. Follow up will occur at 48-72 hour intervals by nurses on any scripts not received until they are received. Nursing will be in-service on this process any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as appropriate. The ADON/Designee will verify 5 days weekly that pain medications are on the Medication Administration Records as ordered and being administered as ordered. These results will be reviewed in CQI meeting daily for 4 weeks, then weekly for 4 weeks. Reviews will continue randomly ongoing. Any concerns or patterns found will be addressed by the QA committee and a plan will be devised and reviewed weekly by the Administrator until resolution. Completion date: 12-26-2014</p>				

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	<p>The Administrator was interviewed on 12/1/14 at 2:45 p.m. The Administrator indicated the nurse on duty had called the wrong physician related to the need for orders for Resident #B. The Administrator indicated the the facility did not have the resident's Norco medication in supply due to problems obtaining a written prescription and they had all been used from the emergency drug kit (EDK). She indicated the staff were attempting to get an order to use Hydrocodone/APAP 10/325 mg in place of 2 Norco tablets because the 10 mg medication was still in supply in the EDK.</p> <p>The Administrator indicated the order received by the wrong physician on 11/1/14 at 8:21 p.m. was not written after the nurse discovered he had called the wrong physician. She indicated an order was obtained very early the next morning from the resident's personal physician, but the order was not recorded in the nursing notes until 11/2/14 at 12 noon. This order, dated 11/2/14, indicated the staff could give Hydrocodone/APAP 10/325 mg tab 1 three times daily till the routine Norco 5/325 mg tablets were available from the pharmacy. This order was written on the November Medication Administration Record (MAR), but the times were listed at 9 a.m., 5 p.m. and 1</p>			

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	<p>a.m. The November 2014 MAR lacked documentation of any of the medication having been given after the order was received.</p> <p>The November 2014 MAR lacked documentation of any Norco pain medication having been given on 11/2/14 at 6 a.m. and 2 p.m. The MAR lacked documentation of any Norco pain medication having been given on 11/3/14. A notation of "HOLD" was written in the columns where the initials would have been written to signify the med was given.</p> <p>The nursing notes for 11/2 and 11/3/14 lacked any information related to the resident not receiving her pain medication as ordered and/or pain assessment or monitoring having been done.</p> <p>The Administrator and DON were interviewed on 12/1/14 at 3 p.m. Additional information was requested related to the resident receiving her pain medication timely, what doses may not have been given, and narcotic sign out information related to the meds having been removed from the EDK for resident use.</p> <p>The DON was interviewed on 12/2/14 at</p>			

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	<p>10:15 a.m. The following information was provided:</p> <p>She indicated verbal contact with the pharmacy had to be made and an authorization number given before narcotic medications could be removed from the EDK. A "Box Usage Report" sheet must be filled out and put in the EDK when the medication was removed which contained the authorization number.</p> <p>No authorization could be found for the 11/2/14 6 a.m. dose of Norco and/or Hydrocodone/APAP 10/325 mg to be removed from the EDK kit, no "Box Usage Report" could be found, and the medication was not charted as given.</p> <p>Authorization for the 11/2/14 2 p.m. dose of Hydrocodone/APAP 10/325 mg was found and provided, but the medication was not charted as having been given on the November 2014 MAR.</p> <p>Authorization for a 11/2/14 10 p.m. dose of Hydrocodone/APAP 10/325 mg was found and provided, but the medication administration was charted on the Norco section of the MAR in error instead of the Hydrocodone/APAP 10/325 mg section of the MAR.</p>						

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F000386 SS=D	<p>The pharmacy staff were able to find an authorization number in their notes in the pharmacy for all three doses on 11/3/14, but no "Box Usage Report" had been completed for any of those 3 doses and those doses had not been charted as having been given in any location on the November 2014 MAR.</p> <p>The DON indicated the resident's routine supply of Norco medication was received on 11/3/14, but the time was unknown, and the MAR did not indicate it was resumed and given as ordered until the 6 a.m. dose on 11/4/14.</p> <p>This federal tag relates to Complaint IN00158962.</p> <p>3.1-37(a)</p> <p>483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. Based on record review and interview, the facility failed to ensure each resident's</p>	F000386	F 386 Resident B was visited by the	12/26/2014			

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	<p>plan of care was reviewed by their physician and progress notes were written and signed in regards to each visit for 1 of 3 residents reviewed for physician visits and completion of progress notes in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 12/1/14 at 11:20 a.m. Diagnoses for the resident included, but were not limited to; joint pain, multiple sites; secondary Parkinson's; and dementia with behavioral disturbances.</p> <p>The last signed recapitulation (recap) of physician's orders for Resident #B was dated 9/9/14. This was the only signed recap in the clinical record at that time. The clinical record lacked any progress note having been made by the physician related to this visit.</p> <p>The last progress note in the clinical record made by the resident's attending physician was dated 2/28/14.</p> <p>The Administrator and DON were interviewed on 12/1/14 at 12:20 p.m. Additional information was requested related to physician visits and signed progress notes for Resident #B since the physician progress note dated 2/28/14.</p>		<p>attending physician 11/5 and 12/9/14 while no new orders were written and progress note was written.</p> <p>Residents who reside in the facility have had their records reviewed for timeliness of signed physician orders and physician progress notes. The clinical records are now current. Going forward by the 15th of the month the ADON/Designee will verify that the clinical records for the residents contain timely signed progress notes as well as current RECAPS (plan of care). This will be ongoing.</p> <p>During the first week of each month the ADON/Designee will acquire signatures for unsigned orders /POS from attending MD. These orders will be reviewed, signed and returned. Any unsigned orders will be followed upon 48-72 hour intervals by telephone and in writing by nursing until all orders are received back. This will be ongoing. Nurses will be in serviced on this process any staff who fails to comply with the points of the in-service will be further educated and /or progressively disciplined as appropriate.</p> <p>A log of outside physician orders will be maintained by the ADON/Designee to review weekly at CQI meetings. Review of findings will be brought to facility QA meetings. Any concerns/patterns will be addressed by the QA committee.</p>				

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F000387 SS=D	<p>The Administrator and DON were interviewed on 12/1/14 at 2:45 p.m. The DON provided the following information:</p> <p>February 2014 recap- signed 2/28/14 and progress note made as noted above. June 2014 recap- now signed 12/1/14 August 2014 recap- signed 8/14/14 -- No progress note was made in regards to this visit. September 2014 recap- signed 9/9/14- No progress note was made in regards to this visit. November recap- now signed 12/1/14 December recap- now signed 12/1/14</p> <p>The Administrator indicated the items signed on 12/1/14, as noted, had been faxed to the physician's office for signatures and the resident had not been seen by the physician. No progress notes were made in regards to the signed orders on 12/1/14 as noted.</p> <p>This federal tag relates to Complaint IN00158962.</p> <p>3.1-22(c)(1) 3.1-22(c)(2)</p> <p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF</p>		<p>Their action plan will be reviewed weekly by the Administrator until resolution. Completion date: 12-26-2014</p>		

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	<p>PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility failed to ensure each resident was seen by their physician at least every sixty days for 1 of 3 residents reviewed for timeliness of physician visits. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 12/1/14 at 11:20 a.m. Diagnoses for the resident included, but were not limited to; joint pain, multiple sites; secondary Parkinson; and dementia with behavioral disturbances.</p> <p>The last signed recapitulation (recap) of physician's orders for Resident #B was dated 9/9/14. This indicated a time period of 82 days since the last recap of physician's orders was signed. This was the only signed recap in the clinical record at that time. The November and December recaps were unsigned.</p> <p>The last progress note in the clinical record made by the resident's attending</p>	F000387	<p>F 387</p> <p>Resident B was visited by the attending physician on 11/5/14 and 12/9/14 while no new orders were written a progress note was written.</p> <p>Residents who reside in the facility have had their records reviewed for timeliness of physician visits. Residents records in compliance at this time. Going forward a log of physician visits will be maintained by the DON/ADON/Designee to verify and track timeliness of physician visits. Any physician who does not make a timely physician visit will be reminded by telephone and in writing within 72 hours of the missed date. These reminders will continue at 48-72 hour intervals until the visit is made. This practice will be ongoing. Nurses will be in-serviced on this process.</p> <p>The DON/ADON/Designee will keep a log to track timeliness of physician visits. The log will be reviewed weekly in CQI meeting. Any discrepancy patterns will be addressed by the QA committee and their action plan will be reviewed weekly by the</p>	12/26/2014

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	<p>physician was dated 2/28/14.</p> <p>The Administrator and DON were interviewed on 12/1/14 at 12:20 p.m. Additional information was requested related to physician visits with recaps being signed and progress notes made for Resident #B since the physician progress note dated 2/28/14.</p> <p>The Administrator and DON were interviewed on 12/1/14 at 2:45 p.m. The DON provided the following information:</p> <p>February 2014 recap- signed 2/28/14 June 2014 recap- now signed on 12/1/14 August 2014 recap- signed 8/14/14 -- A time period of 167 days since the last recapitulation of physician orders was signed on 2/28/14. September 2014 recap- signed 9/9/14 November recap- now signed 12/1/14 December recap- now signed 12/1/14</p> <p>The Administrator indicated the items signed on 12/1/14 had been faxed to the physician's office for signatures and the resident had not been seen by the physician. The Administrator indicated the resident had been out to see her physician in his office on 11/5/14, but no orders had been signed and returned at that time.</p>		<p>Administrator until resolution. Completion date: 12-26-2014</p>		

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F000514 SS=D	<p>This federal tag relates to Complaint IN00158962.</p> <p>3.1-22(d)(1) 3.1-22(d)(2)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented in regards to physician contact information and/or medication administration for 2 of 3 residents reviewed for complete and accurate medical records in a sample of 3. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #B</p>	F000514	F514 Resident B and Resident C were both assessed for any adversereactions related to lack of documentation in their MAR's 11/29/14 and 11/30/14and none were noted. An audit of the MAR's was completed for residents residingin the facility to check for lack of documentation in the MAR's 11-29/14 and11-30/14. Affected residents were assessed and no negative findings werediscovered related to the lack of documentation.	12/26/2014			

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	<p>was reviewed on 12/1/14 at 11:20 a.m. Diagnoses for the resident included, but were not limited to; joint pain, multiple sites; secondary Parkinson's; and dementia with behavioral disturbances.</p> <p>A nursing note, dated 11/1/14 at 8:21 p.m., indicated the nurse on duty had called a family member of Resident #B and notified the family member that a new order had been received from a doctor "on call" for [name of former Medical Director]. The note indicated the family member notified the nurse on duty that the former Medical Director was not the resident's physician and asked the nurse to call the resident's personal physician related to the need for an order.</p> <p>The Administrator was interviewed on 12/1/14 at 2:45 p.m. The Administrator indicated the nurse on duty had called the wrong physician related to the need for orders for Resident #B. The Administrator indicated the "Face sheet" for Resident #B had not been updated timely and contained the wrong information for the resident and had now been corrected.</p> <p>The November 2014 Medication Administration Record (MAR) for Resident #B indicated she had orders</p>		<p>An in-service was held for nursing staff who administer medications which covered the policy for Medication Administration including documentation. Any staff who fail to comply with the points of the in-service will be further educated and /or progressively disciplined as appropriate. The nursing staff who failed to document per requirement of facility policy and per regulation has been counseled and in-serviced. Going forward the MAR documentation will be verified by the on-coming nurse with the off-going nurse shift to shift. Any omissions will be addressed appropriately based on circumstances. The DON/ADON/Designee will complete an audit 5 days weekly of the MAR's for two weeks. Then the audit will continue weekly ongoing. Results of this monitoring will be reviewed in the CQI meetings weekly. Any concern/patterns will be addressed by the QA committee. Their action plan will be reviewed by the Administrator weekly until resolution. Completion date: 12-26-2014</p>		

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(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
	<p>which included, but were not limited to, the following medications:</p> <p>Lidoderm Patch 5% (a medicated patch applied for pain relief) - "apply topically to lower back once daily (up to 12 hours per day, then remove)" --The MAR lacked any documentation of this patch having been applied at 8 a.m. on 11/29 and 11/30/2014.</p> <p>Benazepril (a medication given to lower the blood pressure) 20 milligrams (mg) "tab 1 daily at 9 a.m."--The MAR lacked documentation of this medication having been given on 11/29/14.</p> <p>Pantoprazole (a medication given for pancreatitis) "20 mg tab 1 daily at 9 a.m."--The MAR lacked any documentation of this medication having been given on 11/29/14.</p> <p>Lidoderm 5% patch- "apply 1 patch tropically to left knee once daily at 8 a.m."--The MAR lacked any documentation of this patch having been applied on 11/19 and 11/30/14.</p> <p>Preservision (a multivitamin)- "tab 1 twice daily for eye health at 9 a.m. and 9 p.m."--The MAR lacked any documentation of this medication having been given on 11/19/14 at 9 a.m.</p>			

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	<p>Carbidopa/Levodopa 25-100 (a medication given for Parkinson's disease) "1/2 tablet by mouth 3 times daily at 6 a.m., 2 p.m., and 10 p.m."- The MAR lacked any documentation of this medication having been given at 2 p.m. on 11/29/14.</p> <p>2. The clinical record for Resident #C was reviewed on 12/1/14 at 2:15 p.m. Diagnoses for the resident included, but were not limited to, diabetes mellitus and chronic obstructive pulmonary disease.</p> <p>The November 2014 Medication Administration Record (MAR) for Resident #C indicated she had orders which included, but were not limited to, the following medications:</p> <p>Aspirin "81 mg by mouth once daily at 9 a.m."-- The MAR lacked any documentation of this medication having been given on 11/29 and 11/30/14.</p> <p>Duloxetine (an antidepressant) "30 mg daily at 9 a.m."--The MAR lacked any documentation of this medication having been given on 11/29 and 11/30/14.</p> <p>Colace (a stool softener) "twice daily at 9 a.m. and 9 p.m."--The MAR lacked any documentation of this medication having</p>			

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	<p>been given at 9 a.m. on 11/29 and 11/30/14.</p> <p>Niferex (an iron supplement) "twice daily at 9 a.m. and 9 p.m." --The MAR lacked any documentation of this medication having been given at 9 a.m. on 11/29 and 11/30/14.</p> <p>Gabapentin (a medication given for neuropathy) "100 mg three times daily at 9 a.m., 1 p.m., and 9 p.m."-- The MAR lacked any documentation of this medication having been given at 9 a.m. and 1 p.m. on 11/29 and 9 a.m. on 11/30/14.</p> <p>3. The Administrator was interviewed on 12/1/14 at 3:50 p.m. Additional information was requested related to the missing documentation as noted for Resident's #B and #C.</p> <p>LPN #1 was interviewed on 12/1/14 at 4:25 p.m. She indicated she was the nurse working the day shift on 11/29/14. She indicated it had been a very busy day and she had sent a resident out to the hospital and was trying to complete all her other work. She indicated she knew she had completed her medication passes, but had failed to go back and chart the medications after they were given.</p>						

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	<p>The DON was interviewed on 12/1/14 at 4:30 p.m. She indicated the day shift nurse had called in on 11/30/14 and the night shift nurse had worked over until around 10 a.m. when the Assistant DON (ADON) came in to relieve her. The nurse who stayed over was not available for interview.</p> <p>The ADON was interviewed on 12/1/14 at 4:40 p.m. She indicated she came in around 10 a.m. on 11/30/14 and helped the night shift nurse finish passing the morning meds and then she gave the day shift meds for the rest of the day. She indicated it was a very busy day, but she knew all the medications had been given and she had failed to chart all of them due to the busy day.</p> <p>4. Review of the current facility policy, dated June 10, 2012, provided by the Administrator on 12/1/14 at 4:40 p.m., titled "Drug Administration-General Guidelines", included, but was not limited to, the following:</p> <p>"...Procedures:</p> <p>...8. Only the licensed or legally authorized personal who prepare medication may administer it. This individual records the administration on the resident's MAR at the time the</p>						

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	<p>medication is give. At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that all necessary doses were administered and all administered doses were documented...."</p> <p>This federal tag relates to Complaint IN00158962.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				