

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/26/2014
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NAME OF PROVIDER OR SUPPLIER LINCOLNSHIRE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8380 VIRGINIA ST MERRILLVILLE, IN 46410
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F000000	<p>This visit was for the Investigation of Complaints IN00145467 and IN00146039</p> <p>Complaint IN00145467-Substantiated. Federal/State deficiency related to the allegations was cited at F282.</p> <p>Complaint IN00146039-Substantiated. No deficiencies related to the allegation are cited.</p> <p>Survey Dates: March 26, 2014</p> <p>Facility number: 000577 Provider number: 155650 AIM number: 100266950</p> <p>Survey team: Regina Sanders, RN-TC Yolanda Love, RN</p> <p>Census bed type: SNF/NF: 80 Total: 80</p> <p>Census Payor type: Medicare: 18 Medicaid: 56 Other: 6</p>	F000000		
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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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	<p>Total: 80</p> <p>Sample: 8</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 29, 2014, by Janelyn Kulik, RN.</p>			
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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow residents' physician's orders and care plan, related to medications for 2 of 5 residents reviewed for medication errors in a total sample of 8. (Residents #B and #J)</p> <p>Findings include:</p> <p>1. Resident #J's record was reviewed on 03/26/14 at 12:50 p.m. The resident's diagnoses included, but were not limited to, renal failure, schizophrenia and traumatic brain injury.</p> <p>A Physician's Order, dated 02/06/14, indicated an order for valproic acid (mood stabilizing drug) 250 mg (milligrams) per 5 ml (milliliters), give 25 ml twice a day and 30 ml at bedtime.</p> <p>The resident's Medication Administration Record (MAR), dated 02/2014, indicated the resident had received vaproic acid 25 ml at 5 a.m., 9 a.m., 1 p.m. and 5 p.m. and the 30</p>	F000282	<p>F282</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified: Resident #J- Order for Valproic Acid was corrected, physician notified and medication error report completed.</p> <p>Resident #B- Medication Error report completed for doses not administered timely as indicated in 2567, and physician was notified.</p>	04/14/2014
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	<p>ml of vaproic acid at 9 p.m. from 02/06/14 through 02/28/14.</p> <p>The MAR, dated 03/2014, indicated the resident had continued to received vaproic acid 25 ml at 5 a.m., 9 a.m., 1 p.m., 5 p.m. and 30 ml at 9 p.m. from 03/01/14 through 03/19/14.</p> <p>A Medication Error Report, dated 02/11/14, indicated the physician had given an order for valproic acid 25 ml twice a day and 30 ml at bedtime and the Nurse obtaining the order failed to discontinue the old orders, which resulted in the resident receiving the valproic acid 25 ml four times a day instead of twice a day as ordered. The report indicated an inservice was held on discontinuing previous orders when adding new orders.</p> <p>The resident continued to receive the 25 ml of vaproic acid four times a day and the 30 ml at bedtime after the Medication Error Report was completed on 02/11/14.</p> <p>The resident's valproic acid levels were as follows, with normal range of 50-100: 1/23/14-56.2 2/18/14-48.4 3/13/14-67.7 3/18/14-147.8 (alert was given to the</p>		<p>2) How the facility identified other residents:</p> <p>Medication error reports will be reviewed for the last 90 days to ensure all medication errors were corrected. Any errors noted will be corrected and physicians notified as appropriate.</p> <p>Location of Administration Report will be reviewed for the last 30 days on all residents receiving insulin injections to identify insulin doses not administered timely. Medication error reports will be completed and physicians notified as appropriate.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses will be educated regarding procedure for inputting medication changes and discontinuing previous orders.</p> <p>Licensed nurses and QMA's will be educated regarding compliance with medication administration time frames of up to one hour prior to and one hour after scheduled administration times, and medications must be documented at the time medications were administered.</p> <p>Medication order changes will be reviewed for at least 5 residents per week to ensure orders are</p>				

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	<p>facility)</p> <p>A Nurses' Note, dated 03/18/14 at 8:16 p.m. indicated the resident had a new order to hold the valproic acid for one day and repeat the level on 03/20/14 due to the abnormal lab result.</p> <p>A Physician's Order, dated 03/18/14, indicated to hold the valproic acid for one day.</p> <p>During an interview on 03/26/14, the A-Wing Unit Manager indicated the resident had continued to receive the valproic acid 25 ml four times a day, even after the medication error had been found on 02/11/14.</p>		<p>entered correctly and previous orders discontinued as indicated.</p> <p>Location of Administration Report will be reviewed on at least 5 residents per week receiving insulin to ensure insulin was administered and documented timely as ordered by the physician.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of Compliance. April 14, 2014</p>	

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>2. The record for Resident #B was reviewed on 3/26/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to, hypertension, diabetes, Alzheimer's, depression, and debility.</p> <p>Review of the Medication Administration Records (MARs) dated 2/2014 and 03/2014, indicated an order for sliding scale (insulin given per blood glucose test result) Novolog (insulin) subcutaneous (under the skin) two times a day to be administered at 7:00 a.m. and 4:00 p.m., with the following doses: Give 2 units when Blood Sugar= 151-200 Give 4 units when Blood Sugar= 201-250 Give 6 units when Blood Sugar= 251-300 Give 8 units when Blood Sugar= 301-350 Give 10 units when Blood Sugar = 351-400 Call MD (medical doctor) if Blood Sugar below 59 and above 401.</p>	F000282	<p>F282</p> <p>The facility requests paper compliance for this citation.</p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified: Resident #J- Order for Valproic Acid was corrected, physician notified and medication error report completed.</p> <p>Resident #B- Medication Error report completed for doses not administered timely as indicated in 2567, and physician was notified.</p>	04/14/2014
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	<p>Review of the, "Location of Administration Report", dated 2/1/2014 thru 2/28/2014, indicated Novolog administration date and times as follows:</p> <p>-2/8/2014 at 9:59 a.m. -2/9/2014 at 8:24 a.m. -2/11/2014 at 8:29 a.m. -2/27/2014 at 9:00 a.m.</p> <p>Review of the, "Location of Administration Report", dated 3/1/2014 thru 3/31/2014, indicated Novolog administration date and time as follows:</p> <p>-3/1/2014 at 9:30 a.m.</p> <p>Further review of the MARs dated 2/2014 and 03/2014, indicated an order for Levemir (insulin) 15 units subcutaneous one time a day to be administered at 9:00 a.m.</p> <p>Review of the, "Location of Administration Report", dated 2/1/2014, thru 2/28/2014, indicated Levemir administration date and times as follows:</p> <p>-2/6/2014 at 12:14 p.m. -2/9/2014 at 11:12 a.m. -2/23/2014 at 12:46 p.m. -2/27/2014 at 10:41 a.m.</p>		<p>2) How the facility identified other residents:</p> <p>Medication error reports will be reviewed for the last 90 days to ensure all medication errors were corrected. Any errors noted will be corrected and physicians notified as appropriate.</p> <p>Location of Administration Report will be reviewed for the last 30 days on all residents receiving insulin injections to identify insulin doses not administered timely. Medication error reports will be completed and physicians notified as appropriate.</p> <p>3) Measures put into place/ System changes:</p> <p>Licensed nurses will be educated regarding procedure for inputting medication changes and discontinuing previous orders.</p> <p>Licensed nurses and QMA's will be educated regarding compliance with medication administration time frames of up to one hour prior to and one hour after scheduled administration times, and medications must be documented at the time medications were administered.</p> <p>Medication order changes will be reviewed for at least 5 residents per week to ensure orders are</p>				

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	<p>Review of the, "Location of Administration Report", dated 3/1/2014 thru 3/31/2014, indicated Levemir administration date and times as follows:</p> <p>-3/10/2014 at 12:08 p.m. -3/22/2014 at 11:11 a.m. -3/23/2014 at 11:53 a.m. -3/24/2014 at 11:02 a.m. -3/25/2014 at 10:50 a.m.</p> <p>Review of the Care Plan dated 11/11/2013, indicated a plan of care for the diagnosis of diabetes mellitus (high blood sugar). The goal indicated the resident would not have complications related to diabetes through the review date 4/14/2014. The interventions included, but were not limited to, administer diabetic medications as ordered by the Physician.</p> <p>Interview with LPN #4, on 03/26/14 at 11:00 a.m., indicated nursing staff sign the MAR directly after a medication was administered. She also indicated one nurse must remain in the dining room during breakfast which may cause medications to be administered late. Continued interview further indicated medications may also be</p>		<p>entered correctly and previous orders discontinued as indicated.</p> <p>Location of Administration Report will be reviewed on at least 5 residents per week receiving insulin to ensure insulin was administered and documented timely as ordered by the physician.</p> <p>4) How the corrective actions will be monitored:</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p> <p>5) Date of Compliance. April 14, 2014</p>				

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	<p>administered late if the resident was not available.</p> <p>Interview with the B-Wing Unit Manager, on 03/26/14 at 11:15 a.m., indicated it was her expectation of her nursing staff to sign the MAR directly after the medications were administered. She also indicated nursing staff have an one hour window in which to administer medications and nursing staff may administer medications one hour before and one hour after the indicated time on the MAR.</p> <p>Interview with the DoN (Director of Nursing), on 03/26/14 at 3:16 p.m., indicated audits were completed to ensure medications were being administered as ordered.</p> <p>A Professional Resource, titled, "Qualified Medication Aide Basic Curriculum", dated 10/03, Lesson 30, indicated, "...Medications my be administered 60 minutes earlier or later than the scheduled time of administration..."</p> <p>This Federal tag relates to Complaint IN00145467.</p> <p>3.1.35.(g)(2)</p>				

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