

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 02/10/2012
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NAME OF PROVIDER OR SUPPLIER EMERITUS AT GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7212 US HWY 31 S INDIANAPOLIS, IN 46227
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R0000	<p>This visit was for the Investigation of Complaint IN00102446.</p> <p>Complaint IN00102446 substantiated, state residential findings related to the allegation are cited at 064 and 090.</p> <p>Survey dates: February 09 and 10, 2012</p> <p>Facility number: 003283 Provider number: 003283 AIM number: N/A</p> <p>Survey team: Kimberly Perigo, RN</p> <p>Census bed type: Residential: 63 Total: 63</p> <p>Census payor type: Other: 63 Total: 63</p> <p>Sample: 07</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 2/14/12 Cathy Emswiller RN</p>	R0000		

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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R0064	<p>410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident.</p> <p>Based on interviews and review of records the facility failed to exercise reasonable care for the protection of residents' narcotic medications from theft for 2 of 4 residents reviewed for narcotic medication discrepancies in a sample of 7; in that the facility failed to ensure accurate shift to shift counting of narcotic medications as indicated by the facility's Medication Professional Practice Guidelines Policy. [Residents D and E] [LPN #1]</p> <p>Findings include:</p> <p>The Nursing Spectrum Drug 2010 Handbook indicated; "The Controlled Substance Act of 1970 regulates the production and distribution of stimulants, narcotics, depressants, hallucinogens, and anabolic steroids. Drugs regulated by this law fall into five categories, or schedules, based on their abuse potential, medicinal value, and harmfulness. Schedule I drugs are the most hazardous; schedule V drugs, the least hazardous."</p>	R0064	<p>I. Corrective Action: Residents D & E's Narcotic medication records were audited on 2/29/12 and found to be accurate.II. How to Identify Other Residents: An audit of residents receiving narcotic medications was completed on 2/29/12 by the Emeritus Regional Director of Quality Services and found to be accurate.III.Systemic Changes: Inservice with Nurses/QMA's on shift to shift narcotic counts, policy and procedure of medication destruction, legible documentation to be completed by the Emeritus Regional Director of Quality Services on March 1, 2012. A new controlled substance record book to also be inserviced on 3/1/12 and implemented on 3/4/12. LPN #1 was terminated on 1/23/12.IV. Monitoring Process: Resident Care Director and/or designee will monitor narcotic count sheets 5 times per week for 2 wks., 3 times per wk. for 2 wks., then weekly with medication review audit. CQI committee will review monthly to ensure sustained compliance: if during an audit a signature is missing, a complete narcotic</p>	03/02/2012			

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	<p>Taber's Medical Cyclopedia indicated; "The Controlled Substance Act specifies accurate record keeping for the dispensing of controlled substances."</p> <p>1) Resident D's residential records were reviewed on February 09, 2012 at 1:15 p.m.</p> <p>Resident D's Controlled Substance Record for Oxycotin [controlled substance schedule II] 20 mg tablet dated December 25, 2011 at 5:00 p.m. and signed off by LPN #1 indicated; "5:00 p.m. i [one] sent c [with] resident." Review of residential records and interview of the Residential Care Director on February 10, 2012 at 12:00 p.m.; indicated Resident D had not gone anywhere and if Resident D had gone somewhere, their controlled medications cannot be sent with them.</p> <p>Resident D's Controlled Substance Record for Oxycodone HCL [controlled substance schedule II] 5 mg tablet [order: give one tablet] dated January 05, 2012 at 9:00 p.m. and dated January 06, 2012 at 9:00 p.m. indicated two tablets were signed off by LPN #1.</p> <p>Resident D's Controlled Substance Record for Oxycotin 20 mg tablet dated</p>		<p>count will be performed at that time by the Resident Care Director or designee. If any discrepancy is found, a report will be filed with ISDH and or the local law enforcement agency. Regional Directors will monitor during routine visits and during annual Comprehensive Review Process. V. Date of Completion: March 2, 2012</p>				

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	<p>January 12, 2012 at 5:00 p.m. and signed off by LPN #1 indicated; "destroyed due to contamination." A second signature, of having witnessed the destruction of the medication, was not documented.</p> <p>Interview of the Residential Care Director on February 10, 2012 at 12:00 p.m.; indicated any controlled medications that are destroyed are to be witnessed by a second person. The second person then signs the Controlled Substance Record to indicate having witnessed the destruction.</p> <p>Resident D's Controlled Substance Record for Narco [controlled substance schedule III] 5-500 mg tablet indicated [date not documented] "narc sheet was missing. LPN [LPN#1] stated new sheet count @ 8." Interview of the Residential Care Director on February 10, 2012 at 12:00 p.m.; indicated the previous Controlled Substance Record was not located and the facility could not verify if any Narc 5-500 mg tablets were missing.</p> <p>2) Resident E's residential records were reviewed on February 09, 2012 at 1:25 p.m.</p> <p>Resident E's Controlled Substance Record for Oxycontin 80 mg tablet dated December 22, 2011 at 8:00 p.m. and signed off by LPN #1 indicated, "spilled H2O [water] in med cup destroyed." A</p>			

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	<p>second signature, of having witnessed the destruction of the medication, was not documented.</p> <p>Resident E's Controlled Substance Record for Oxycontin 10 mg tablet dated December 22, 2011 at 8:00 p.m. and signed off by LPN #1 indicated, "destroyed got wet in med cup." A second signature, of having witnessed the destruction of the medication, was not documented.</p> <p>Resident E's Controlled Substance Record of Oxycontin 80 mg tablet dated January 05, 2012 at 9:00 p.m. indicated LPN #1 signed off and administered one tablet. Following the administration of the 9:00 p.m. tablet, the record was smeared through and the medication count was incorrect.</p> <p>Review on February 09, 2012 at 10:15 a.m. of the facilities Controlled Drugs-Count Records for three of three medication carts indicated:</p> <p>Medication Cart One: non-documentation of signature(s) for January 2012 across three shift - 51 times non-documentation of signature(s) for February 01 - 09, 2012 across three shifts - 46 times</p>			

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	<p>Medication Cart Two/Memory Care: non-documentation of signature(s) for January 2012 across three shifts - 44 times non-documentation of signature(s) for February 01 - 09, 2012 across three shifts - 13 times</p> <p>Medication Cart Three: non-documentation of signature(s) for January 2012 across three shifts - 26 times non-documentation of signature(s) for February 01 - 09, 2012 across three shifts - 46 times</p> <p>The Facilities Medication Professional Practice Guidelines Policy dated September 29, 2010; provided by the Administrator indicated, "Policy: Medications are to be administered/assisted within current professional practice guidelines designated by the state in which the professional practices, labeled precautions and literature devoted to medication administration. ... Controlled Substances/Medications: In order to guard against the theft and/or unlawful diversion of controlled substances, community shall follow procedures as outlined below. ... Documentation: Complete both the MAR [Medication Administrator Record] and the Controlled</p>			

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	<p>Substance Quantity Count Record forms when receiving or giving controlled medications. Complete Controlled Substance Shift Count Record at each shift change, a minimum of three times per day."</p> <p>Interview on February 09, 2012 at 10:15 a.m.; with the Residential Care Director indicated at the change of each shift [three times a day] the off going and on coming nurse are to count the controlled medications to ensure an accurate count and distribution is being implemented. The Residential Care Director further indicated several signatures were not present on the Controlled Drug Records, which would verify to her an accurate controlled drug count was not being done.</p> <p>LPN #1's personnel records were reviewed on February 09, 2012 at 1:45 p.m. LPN's date of hire was December 15, 2011. A Corrective Action Form dated January 09, 2012; indicated LPN #1's employment was terminated due to, ".. After interviewing several residents and families it was found that residents were not getting there medications during his shift. On a continuous basis discrepancies in Narc counts have been an ongoing issue during his shifts."</p> <p>This State Residential Finding relates to</p>			

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	Complaint IN00102446.			

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R0090	<p>410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be</p>						

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	<p>available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interviews and review of records the facility failed to inform the division within twenty-four hours of becoming aware of 1 of 3 incidents of an unusual occurrence, in that the facility failed to inform the division of known narcotic medication discrepancies. [LPN #1]</p> <p>Findings include:</p> <p>1) Resident D's residential records were reviewed on February 09, 2012 at 1:15 p.m.</p> <p>Resident D's Controlled Substance Record for Oxycontin [controlled substance schedule II] 20 mg tablet dated December 25, 2011 at 5:00 p.m. and signed off by LPN #1 indicated; "5:00 p.m. i [one] sent c [with] resident." Review of residential records and interview of the Residential Care Director on February 10, 2012 at 12:00 p.m.; indicated Resident D had not gone anywhere and if Resident D had gone somewhere, their controlled medications</p>	R0090	<p>I. Corrective Action: An Incident Report was submitted to ISDH on 3/1/12 addressing narcotic discrepancies.II. How to Identify Other Residents: An audit of residents receiving narcotic medications was done on 2/29/12 by Emeritus Regional Director of Quality Services and found to be accurate.III. Systemic Changes:1) The Administrator shall inform the ISDH within 24 hrs of any unusual occurrence.2) If and when a Resident leaves the building during the time a medication administration would occur, a controlled medication could be sent with the resident representative as per the Emeritus Medication Management Program.3) During the destruction of all medications, a witness must be present and must sign off as a witness to the destruction.4) An inservice was conducted on 3/1/12 on the prompt reporting of narcotic count discrepancies and the procedure to follow.IV. Monitoring Process:Events will be monitored by the Administrator and/ or designee to assure that any unusual occurrences be reported to ISDH within 24 hours of</p>	03/02/2012			

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	<p>cannot be sent with them.</p> <p>Resident D's Controlled Substance Record for Oxycodone HCL [controlled substance schedule II] 5 mg tablet [order: give one tablet] dated January 05, 2012 at 9:00 p.m. and dated January 06, 2012 at 9:00 p.m. indicated two tablets were signed off by LPN #1.</p> <p>Resident D's Controlled Substance Record for Oxycontin 20 mg tablet dated January 12, 2012 at 5:00 p.m. and signed off by LPN #1 indicated; "destroyed due to contamination." A second signature, of having witnessed the destruction of the medication, was not documented. Interview of the Residential Care Director on February 10, 2012 at 12:00 p.m.; indicated any controlled medications that are destroyed are to be witnessed by a second person. The second person then signs the Controlled Substance Record to indicate having witnessed the destruction.</p> <p>Resident D's Controlled Substance Record for Narco [controlled substance schedule III] 5-500 mg tablet indicated [date not documented] "narc sheet was missing. LPN [LPN#1] stated new sheet count @ 8." Interview of the Residential Care Director on February 10, 2012 at 12:00 p.m.; indicated the previous Controlled Substance Record was not</p>		<p>occurrence. As stated in POC R064, regular narcotic med audits will be conducted 5 X a wk for 2 wks., 3 X a wk. for 2 wks., then weekly with medication review audit. CQI committee will review montly to ensure sustained compliance: if during an audit a signature is missing, a complete narcotic count will be performed at that time by the Resident Care Director or designee. If any discrepancy is found, a report will be filed with ISDH and or the local law enforcement agency. Emeritus Regional Directors will monitor during routine visits and during annual Comprehensive Review Process.V. Date of Completion: March 2, 2012</p>				

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	<p>located and the facility could not verify if any Narc 5-500 mg tablets were missing.</p> <p>2) Resident E's residential records were reviewed on February 09, 2012 at 1:25 p.m.</p> <p>Resident E's Controlled Substance Record for Oxycontin 80 mg tablet dated December 22, 2011 at 8:00 p.m. and signed off by LPN #1 indicated, "spilled H2O [water] in med cup destroyed." A second signature, of having witnessed the destruction of the medication, was not documented.</p> <p>Resident E's Controlled Substance Record for Oxycontin 10 mg tablet dated December 22, 2011 at 8:00 p.m. and signed off by LPN #1 indicated, "destroyed got wet in med cup." A second signature, of having witnessed the destruction of the medication, was not documented.</p> <p>Resident E's Controlled Substance Record of Oxycontin 80 mg tablet dated January 05, 2012 at 9:00 p.m. indicated LPN #1 signed off and administered one tablet. Following the administration of the 9:00 p.m. tablet, the record was smeared through and the medication count was incorrect.</p>						

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	<p>LPN #1's personnel records were reviewed on February 09, 2012 at 1:45 p.m. LPN's date of hire was December 15, 2011. A Corrective Action Form dated January 09, 2012; indicated LPN #1's employment was terminated due to, ".. After interviewing several residents and families it was found that residents were not getting there medications during his shift. On a continuous basis discrepancies in Narc counts have been an ongoing issue during his shifts."</p> <p>An Event Management and Reporting Policy dated August 26, 2011; provided by the Executive Director indicated, "Event Management Report - Medication Occurrence. ... Complete the Medication Occurrence Worksheet and then submit an Event Management Report within 24 hours or the next business day."</p> <p>The Executive Director was interviewed on February 10, 2012. During the interview the Executive Director indicated the division had not been notified of the controlled medication discrepancies which involved LPN #1.</p> <p>This State Residential Finding relates to Complaint IN00102446.</p>						