

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155512	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/11/2014
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NAME OF PROVIDER OR SUPPLIER PRESENCE SACRED HEART HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 515 N MAIN ST AVILLA, IN 46710
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: March 3, 4, 5, 6, 7, 10, and 11, 2014</p> <p>Facility number: 000404 Provider number: 155512 AIM number: 100290810</p> <p>Survey team: Rick Blain, RN - TC Tim Long, RN (3/03, 3/10, 3/11, 20140 Carol Miller, RN Diane Nilson, RN (3/03, 3/04, 3/05, 3/06, 3/07 3/10, 2014)</p> <p>Census bed type: SNF: 18 SNF/NF: 97 Residential: 8 Total: 123</p> <p>Census payor type: Medicare: 12 Medicaid: 77 Other: 34 Total: 123</p> <p>Residential sample: 7</p>	F000000	<p>Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Presence Sacred Heart Home that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance.</p>	
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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>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 13, 2014 by Randy Fry RN.</p>			

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interviews, the facility failed to notify the physician after a significant change in a wound for 1 of 1 residents reviewed for pressure</p>	F000157	The facility will monitor and treat the pressure ulcer for resident # 76 until resolved. The corrective action to prevent other residents from being affected by the deficient practice is when a	04/01/2014	

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	<p>ulcers (Resident #76).</p> <p>Findings include:</p> <p>The record for Resident #76 was reviewed, at 9:15 a.m., on 3/7/14, and indicated the resident was admitted on 12/17/13. Diagnoses included, but were not limited to: status post left hip fracture/pubis fracture, and End Stage Renal Disease.</p> <p>Review of Departmental nursing notes, indicated the following:</p> <p>12/17/13 Admission assessment completed and indicated an "abraded area on left buttocks 7 cm. (centimeters) by 2.1 cm." The note also indicated the resident was being treated with Mepiflex(a foam dressing for wounds).</p> <p>12/23/13 Notes indicated an abraded area on the left buttocks covered with Mepiflex dressing. The note indicated the resident had limited range of motion of the bilateral upper extremities due to pain in the bilateral shoulders, and limited range of motion of the left lower extremities due to a fracture. Also the resident was non-weight bearing to the left lower extremity, required extensive assistance to transfer from one surface to another,</p>		<p>pressure ulcer is found or there is a significant change in the wound the physician and family will be notified and documented. In addition to skin assessments, all wound/pressure areas will be measured and documented on the day shift by the nurse and followed up by the wound certified nursing staff. Measurements and documentation completed weekly and physician updated accordingly, monitor and treatment per physicians orders.Wound Round Program and wound book for monitoring documentation and wound rounds. Weekly monitoring of wound progress will be monitored by QA Team.In-service training for nurses will be completed by 4-1-2014 on the physician notification regarding the worsening condition of a wound.Unit nurse responsible, D.O.N./A.D.O.N. to monitor for 12 months and report to QA Team monthly for 12 months for additional monitoring.</p>				

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	<p>was able to guide bilateral lower extremities to the edge of the bed but not over the edge of the bed, and was not able to assist to pull his upper torso to the upright position. The note further indicated the resident was dependent for bathing, grooming, and dressing and not able to feed himself breakfast due to pain in the bilateral shoulders.</p> <p>1/2/14 The note indicated the abraded area to the buttocks was dry, with no signs of infection, and measured 3 cm. by 1.8 cm., and Mepiflex continued.</p> <p>1/9/14 A wound assessment report, dated 1/9/14, and electronically signed by RN #5, indicated the abrasion to the left buttock had improved, had scant serosanguinous drainage, no signs of infection, and measured 2.80 cm. by 2.00 cm., with no depth.</p> <p>1/12/14 A note, electronically signed by LPN #6 indicated the old dressing was removed from the left buttock, the wound bed was soft black eschar (necrotic tissue) with yellow slough (dead cells which had accumulated in the fluid of the wound) in the center, the peri wound was pink, and a new dressing was applied. The note indicated the resident was encouraged when in bed to allow staff to reposition him</p>						

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	<p>from his back.</p> <p>There was no documentation the physician was notified regarding the worsening condition of the wound.</p> <p>The next entry regarding the wound was documented 4 days later, on 1/16/14 at 1:53 a.m., and indicated the area to the left buttocks measured 3.5 cm. by 3 cm. by 0.1 cm. The area had a moderate amount of serous drainage, a foul odor, and slough to the upper wound. A new dressing was applied, and the resident was encouraged to lay on his side.</p> <p>Another departmental nursing note, dated 1/16/14, at 1:23 p.m., indicated per the wound team, the Stage 3 wound area was to be washed with wound wash, Santyl applied to the slough, then Zeroform, and a dry dressing applied. Also the note indicated the physician was notified .</p> <p>A fax to the physician, dated 1/16/14, indicated the resident was admitted with an abrasion to the left buttocks. This past week, it had a significant change, increased in size, had a foul odor, and a moderate amount of serous drainage. The note indicated a foam dressing was being used, the resident had a poor appetite, and did not like to lay on</p>				

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	<p>his sides.</p> <p>New orders on the fax indicated a low pressure mattress was ordered. Another fax to the physician, dated 1/16/14, indicated the physician approved the wound care teams treatment for Santyl, zeroform, and a dry dressing.</p> <p>Physician orders, dated 1/17/14, also indicated the resident was to be on a regular diet, Pro-mod 1 scoop twice a day, and magic cup daily was ordered.</p> <p>The DNS was interviewed at 10:37 a.m., on 3/10/14, regarding the pressure area and physician notification.</p> <p>The DNS indicated when LPN #6 assessed the wound on 1/12/14, and the wound contained black eschar and yellow slough, the LPN should have contacted the physician due to the worsening condition of the wound. The DNS indicated she was not aware of this change in the wound until 1/16/14, and had not spoken to LPN #6 regarding this wound.</p> <p>The DNS provided a policy Pressure Ulcer Treatment, dated 11/11/10, at</p>						

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F000314 SS=G	<p>1:50 p.m., on 3/10/14. She indicated the facility did not have a policy specifically for physician notification. The policy was reviewed at 2:15 p.m., on 3/10/14. The policy indicated residents with pressure ulcers would have appropriate assessment, intervention and evaluation of treatment implemented. Physicians would be notified of all pressure ulcers.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interviews, the facility</p>	F000314	The facility will monitor and treat the pressure ulcer for resident #	04/01/2014			

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	<p>failed to ensure one resident received timely treatment after a pressure ulcer developed in order to promote healing and prevent infection for 1 of 1 residents reviewed for pressure ulcers (Resident #76).</p> <p>Findings include:</p> <p>The record for Resident #76 was reviewed on 3/7/2014 at 9:15 a.m. and indicated the resident was admitted on 12/17/13. Diagnoses included, but were not limited to: status post left hip fracture/pubis fracture, and End Stage Renal Disease.</p> <p>Review of Departmental nursing notes, indicated the following: 12/17/13 Admission assessment completed and indicated an "abraded area on left buttocks 7 cm. (centimeters) by 2.1 cm." The note also indicated the resident was being treated with Mepiflex(a foam dressing for wounds). 12/23/13 Notes indicated an abraded area on the left buttocks covered with Mepiflex dressing. The note indicated the resident had limited range of motion of the bilateral upper extremities due to pain in the bilateral shoulders, and</p>		<p>76 until resolved. The corrective action to prevent other residents from being affected by the deficient practice is when a pressure ulcer is found or there is a significant change in the wound the physician and family will be notified and documented. In addition to skin assessments, all wound/pressure areas will be measured and documented on the day shift by the nurse and followed up by the wound certified nursing staff. Measurements and documentation completed weekly and physician updated accordingly, monitor and treatment per physician orders. Wound Round Program and wound book for monitoring documentation and wound rounds. Weekly monitoring of wound progress will be monitored by QA Team. In-service training for nurses will be completed by 4-1-2014 regarding timely treatment to a pressure ulcer to promote healing and prevent infection or worsening condition of a wound. Unit nurse responsible, D.O.N./A.D.O.N. to monitor for 12 months and report to QA Team monthly for 12 months for additional monitoring.</p>				

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	<p>limited range of motion of the left lower extremities due to a fracture. Also the resident was non-weight bearing to the left lower extremity, required extensive assistance to transfer from one surface to another, was able to guide bilateral lower extremities to the edge of the bed but not over the edge of the bed, and was not able to assist to pull his upper torso to the upright position. The note further indicated the resident was dependent for bathing, grooming, and dressing and was not able to feed himself breakfast due to pain in the bilateral shoulders.</p> <p>12/23/13 A dietary note, electronically signed by the Dietician, indicated the resident was on a No added salt diet, 1200 cubic centimeters (cc) fluid restriction daily, required some assistance with his meals, and also indicated the resident had an abrasion to the left buttock, and it was being treated by nursing.</p> <p>1/2/14 The note indicated the abraded area to the buttocks was dry, with no signs of infection, and measured 3 cm. by 1.8 cm., and Mepiflex continued.</p> <p>1/9/14 A wound assessment report, dated 1/9/14, and electronically signed by RN #5,</p>				

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	<p>indicated the abrasion to the left buttock had improved, had scant serosanguinous drainage, no signs of infection, and measured 2.80 cm. by 2.00 cm., with no depth.</p> <p>1/12/14 A note, electronically signed by LPN #6 indicated the old dressing was removed from the left buttock, the wound bed was soft black eschar (necrotic tissue) with yellow slough (dead cells which had accumulated in the fluid of the wound) in the center, the peri wound was pink, and a new dressing was applied. The note indicated the resident was encouraged when in bed to allow staff to reposition him from his back.</p> <p>There was no documentation the physician was notified regarding the worsening condition of the wound.</p> <p>The next entry regarding the wound was documented on 1/16/14 at 1:53 a.m., and indicated the area to the left buttocks measured 3.5 cm. by 3 cm. by 0.1 cm. The area had a moderate amount of serous drainage, a foul odor, and slough to the upper wound. A new dressing was applied, and the resident was encouraged to lay on his side. The resident indicated he could not lay on his side for long due to his shoulders.</p>			

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	<p>Another departmental nursing note, dated 1/16/14, at 1:23 p.m., indicated per the wound team, the Stage 3 wound area was to be washed with wound wash, Santyl applied to the slough, then Zeroform, and a dry dressing applied. Also the note indicated the physician was notified .</p> <p>A fax to the physician, dated 1/16/14, indicated the resident was admitted with an abrasion to the left buttocks. This past week, it had a significant change, increased in size, had a foul odor, and a moderate amount of serous drainage. The note indicated a foam dressing was being used, the resident had a poor appetite, and did not like to lay on his sides.</p> <p>New orders on the fax indicated a low pressure mattress was ordered. Another fax to the physician, dated 1/16/14, indicated the physician approved the wound care teams treatment for Santyl, zeroform, and a dry dressing.</p> <p>1/17/14 a nursing note indicated the low pressure mattress was to be delivered today.</p> <p>1/20/14 The wound dressing was changed, and a wound care team member was present. The stage 3 wound measured 3.0 by 1.5 by 0.6 centimeters, with a blanchable peri</p>						

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	<p>wound bed, small amount of slough removed from the wound, and the area under the wound was dark red in color. Santyl was applied to the wound, safegel applied , and the area was packed with aqua cell and a foam dressing was applied. A sacral dressing was applied to help prevent further breakdown. The note further indicated therapy had placed a roho cushion in the wheelchair, and the resident was currently on a low pressure mattress. Also it was recommended the dressing be changed every other day and with any soiling.</p> <p>1/23/14 Stage 3 wound measured 4.0 by 2.0 by 0.5 centimeters, was blanchable peri wound bed, and the middle of wound dark red in color. The note further indicated the physician was updated weekly.</p> <p>The most recent departmental nursing note, dated 3/6/14, indicated a healing Stage 3 pressure area which measured 1.8 cm. by 0.5 cm., by 0.1 cm.</p> <p>Resident #76 was interviewed, at 10:00 a.m., on 3/7//14, and indicated he was going to Dialysis three times a week, and was currently on a regular diet with no fluid restrictions and was doing well. He indicated</p>						

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	<p>both of his shoulders were "bad" and he received pain medication for the pain in his shoulders. He indicated he was admitted to the facility because he had a hip fracture so also had some pain in his hip and had received therapy for the hip fracture, and was currently in restorative therapy.</p> <p>A care plan, dated 12/30/13, indicated the resident was at risk for impaired skin integrity due to decreased bed mobility and overall low Braden score. Approaches included, but were not limited to: Daily skin inspection, report any changes in skin or signs of possible skin breakdown or redness; Encourage/assist to turn at least every 2 hours when in bed; pressure reducing mattress on bed, and a pressure reducing pad in the wheelchair; Nutritional support based on assessment and physician orders, and a lift sheet/slip sheet was to be used to reposition to decrease friction and shear. Another care plan, dated 1/16/14, indicated the resident had a stage 3 pressure area to the left buttock, and the Braden assessment score</p>			

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	<p>indicated the resident was at risk for pressure sores. Additional interventions included, but were not limited to: Monitor daily Treatment as ordered Measure weekly Turn and reposition every 2 hours and as needed Air flow mattress Cushion in wheelchair and magic cup.</p> <p>Physician orders, dated 1/17/14, also indicated the resident was on a regular diet, Pro-mod 1 scoop twice a day, and a magic cup was ordered daily.</p> <p>Resident #76's pressure area was observed, with RN#5 present, at 9:17 a.m., on 3/10/14. A dressing, dated 3/10/14, was partially removed by RN#5 and a pressure area, was observed on the upper left buttocks, approximately 2 cm. by .5 cm., with little depth, and no drainage.</p> <p>The DNS, RN#5, and RN#4 were interviewed, at 10:37 a.m., on 3/10/14, regarding the pressure area. RN#4 indicated she worked on the</p>			

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	<p>rehab unit, and the resident was originally admitted to the rehab unit, due to a hip fracture, was receiving Physical therapy, but was not very compliant. She indicated he was admitted with an abrasion to the left buttocks which he had incurred due to a fall at Dialysis, prior to admission.</p> <p>She indicated at first the resident was transferring with an assist of 2-3 staff members, but then started using a sling lift because he could not stand to bear weight. She indicated at one of the morning staff meetings, they discussed his progress and determined he needed to be moved to a long term care unit where more care could be provided. She indicated he was moved on 12/23/13.</p> <p>The DNS indicated when LPN #6 assessed the wound on 1/12/14, and the wound contained black eschar and yellow slough, the LPN should have contacted the physician due to the worsening condition of the wound. The DNS indicated she was not aware of this change in the wound until 1/16/14, and had not spoken to LPN#6 regarding this wound.</p> <p>The DNS indicated there were 3 certified wound nurses in the building, but they didn't get involved</p>			

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	<p>unless there was a question about a skin condition, or if there was a pressure sore. She indicated the wound nurses should have been involved for Resident #76 on 1/12/14, when the wound worsened. The DNS indicated a low pressure air mattress was ordered on 1/16/14, and prior to the air mattress, the resident had a pressure redistributing (reducing) mattress. The DNS indicated prior to getting the low pressure air mattress, it was more difficult for the resident to turn due to pain in his shoulders, but with the low pressure air mattress, it was easier for him to turn.</p> <p>The policy for Pressure Ulcer Treatment, dated 11/11/10, and provided by the DNS, at 1:50 p.m., on 3/10/14, was reviewed at 2:15 p.m., on 3/10/14.</p> <p>The policy indicated residents with pressure ulcers would have appropriate assessment, intervention and evaluation of treatment implemented. Physicians would be notified of all pressure ulcers.</p> <p>3.1-40(a)(1) 3.1-40(a)(2)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to assess one resident for signs and symptoms of a urinary tract infection while being treated with an antibiotic for 1 of 2 residents reviewed for urinary catheters (Resident #112).</p> <p>Findings include:</p> <p>The record for resident #112 was reviewed on 3/6/2014 at 10:00 A.M. Diagnoses included, but were not limited to, Parkinson's Disease.</p> <p>A laboratory report, dated 2/28/2014, indicated Resident</p>	F000315	The facility will assess for urinary tract infections of residents including those with catheters, monitor antibiotic therapy and follow up treatment. Nurse will initiate infection report upon identification of infection, MAR will be assigned for daily documentation of antibiotic therapy of such symptoms, progress and possible side effects of medication. In-service will be provided to nursing staff by 4-1-2014. A.D.O.N. is responsible, D.O.N. to monitor for 12 months and report to QA Team for 12 months monthly for additional monitoring.	04/01/2014

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	<p>#112's urine culture showed a result of greater than 100,000 organisms per milliliter of Pseudomonas aeruginosa (bacteria) in the urine sample.</p> <p>A physician's order, dated 2/28/2014, indicated Resident #112 was prescribed Cipro (antibiotic medication) 500 mg (milligrams) twice daily by mouth for ten days for a diagnosis of urinary tract infection.</p> <p>A review of the February 2014 and March 2014 Medication Administration Records (Mars) indicated antibiotic charting was to be completed daily on the day shift while the resident was on Cipro.</p> <p>A review of the Nursing Progress Notes for February 2014 and March 2014 did not indicate any documentation of nursing assessments for signs and symptoms of urinary tract infection.</p> <p>The facility Assistant Director of Nursing (ADON) was interviewed on 3/6/2014 at 11:25 A.M. During the interview, the ADON indicated all residents on antibiotics for urinary tract infections were to be assessed by the nurse at least once daily for signs and symptoms of infection</p>				

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R000000	<p>including, but not limited to, temperature, characteristics of urine, and discomfort, and possible side effects of the antibiotic medication. The ADON indicated the assessments were to be documented in the Nursing Notes. The ADON was unable to locate any documentation of the assessments.</p> <p>The facility Director of Nursing (DON) was interviewed on 3/10/2014 at 10:00 A.M. During the interview, the DON indicated the facility had no written policy regarding assessing residents on antibiotics or residents with infections.</p> <p>3.1-41(a)(2)</p> <p>The following residential findings were cited in accordance with 410 IAC 16.2-5.</p>	R000000	Submission of this plan of correction and credible allegation of compliance does not constitute an admission by the certified and licensed provider at Presence				

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R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on record review and interview, the facility failed to ensure one resident who self administered medications was assessed for thye ability to self administer medcations in a sample of 7 residents reviewed (Resident #3).</p>	R000216	<p>Sacred Heart Home that the allegations contained in the survey report are a ture and accurate portrayal of the provision of nursing care and services at this health care facility. Presence Sacred Heart Home, as a licensed and certified provider, recognizes its obligation to provide legally and medically required care and services to our residents in an economic and efficient fashion. Please accept this plan of correction as our written credible allegation of compliance.</p> <p>Resident #3 was assessed to determine safety and desire for self administration of medication, attached. The facility will ensure that residents will be assessed upon admission to determine safety and desire for self administration of medications. Residents will be reassessed</p>	04/01/2014	

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	<p>Findings include:</p> <p>Resident # 3's clinical record was reviewed on 3/11/14 at 9:30 A.M. Review of the resident's most recent physician's orders (2/27/14) indicated six medications the resident was able to self administer. The medications were: Systane Ultra 0.3-0.4%, instill 1 drop into both eyes as needed for dry eyes. May keep at bedside (MKAB); Bayer Back and Body 500milligrams: Take 2 tablets every 6 hours as needed, MKAB; Muro-128 5% eye ointment , apply to both eyes at 9:00 P.M.; Travatan Z 0.004% eye drops: instill 1 drop into both eyes at 9:00 P.M.; Polyethylene Glycol 335: take 17 grams (1 capful) in 4-8 ounces of liquid daily , MKAB; Proair HFA 90 micrograms inhaler: inhale 1 puff every 6 hours as needed, MKAB.</p> <p>An interview with LPN #1 on 3/11/14 at 10:00 A.M. indicated the Resident #3 had no self medication administration assessment completed. LPN #3 indicated the resident had only physician's orders for self administration of certain medications.</p> <p>Review of the policy provided by the administrator on 3/11/14 at 12:00</p>		<p>quarterly and or upon change of condition to ensure safety requirements are met. All current residents will be assessed for self administration of medications per policy requirements and assessments will be completed by 3-19-2014 and quarterly and or upon change of condition thereafter. Nurse responsible, Administrator to monitor monthly for 12 months and report to QA Team for for 12 months for additional monitoring.</p>		

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R000246	<p>P.M., titled: Self-Administration of Medications by Residents, effective date of 2/12/02 indicated under Procedure 2: "If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual ability to carry out this responsibility."</p> <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 interview and record review, the facility failed to ensure documentation was done in the the resident's clinical record. This deficiency affected 1 of 7 residents reviewed for complete documentation in the clinical record (Resident #2).</p> <p>Findings include:</p> <p>The clinical record of Resident #2 was reviewed on 3/11/14 at 9:00</p>	R000246	The administration of all PRN medication administered by a Qualified Medication Assistant (QMA) will be addressed with the a nurse prior to administration. Documentation of nurse notification and symptoms will be documented in the progress notes with date and time. Documentation of PRN medication administration will be documented in the MAR and pain flow sheet (for PRN Medications) and follow up documentation to be completed on flow sheets. Staff will be in-serviced by 3-15-2014	04/01/2014			

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	<p>a.m. The record indicated Resident #2's diagnosis included, but were not limited to, angina (chest pain).</p> <p>The Physician's Order dated 11/23/13 indicated nitrostat 0.4 milligrams (mg) 1 tablet every 5 minutes as needed for chest pain.</p> <p>The January Medication Administration Record indicated on 1/7/14 at 8:00 p.m. the Qualified Medication Aide (QMA) had administered the medication nitrostat 0.4 mg for Resident #2's chest pain.</p> <p>There was no Progress Note for 1/7/ 2014 that indicated the QMA had documented the Nurse was notified prior to the administration of the medication nitrostat to Resident #2.</p> <p>The Administrator was interviewed on 3/11/14 at 12:10 p.m. and indicated the QMA had notified the Nurse prior to administration of the medication nitrostat. The Administrator indicated the QMA had not documented the date or time the Nurse was notified the administration of the medication nitrostat 0.4 mg.</p>		<p>regarding; upon administration of a PRN medication a nurse will be notified and date and time documented. Nurse responsible, Administrator to monitor monthly for 12 months and report to QA team for 12 months to review monthly.</p>				

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	The policy titled Medication and Treatment Signature Form For Nursing was last reviewed on 7/16/13 indicated "...If medication is administered by a Qualified Medication Aide documentation must include date and time nurse notified...."			