

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/30/2015
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NAME OF PROVIDER OR SUPPLIER  WATERFORD CROSSING APARTMENTS	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
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R 000  Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: April 28, 29 and 30, 2015</p> <p>Facility number: 004168 Provider number: 004168 AIM number: N/A</p> <p>Census bed type: Residential: 45 Total: 45</p> <p>Sample: 07</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R 000		
R 117  Bldg. 00	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency</p> <p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on</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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	<p>site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure facility staff had first aid certification for 3 of 10 sampled employees. (Employee #21, Employee #22, Employee #23)</p> <p>Findings include:</p> <p>On 4/29/15 at 2:05 P.M., review of the 10 employee files sampled indicated Employee #21, Employee #22 and Employee #23 did not have first aid certification. All three employees work on the night shift.</p> <p>During an interview, on 4/30/15 at 11:00 A.M., the Director of Nursing (DON) indicated all three employees do not have their first aid certification and they should. The DON further indicated she in-serviced new employees at the start of employment regarding first aid and</p>	R 117	<p><b>R 117 Personnel: Need for staff to have first-aid certification</b> The three employees identified (#21, #22 &amp; #23) as needing first aid certification have been scheduled to attend a first aid training class on May 22, 2015. To our knowledge no residents experienced negative outcomes associated with this finding. All nursing staff (CNAs, QMAs and nurses) will be assessed as to whether they have current first aid certification that goes beyond our current practice of offering first aid training as part of the new-hire orientation process. All nursing department staff (CNAs, QMAs and nurses) will be scheduled to complete first aid certification upon hire if there is no record of current certification. Newly hired staff in the nursing department without CPR and first-aid training will be scheduled to complete certification within the</p>	06/19/2015

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R 120 Bldg. 00	<p>dealing with emergencies but it is not a certification, and there was no policy regarding first aid certification.</p> <p>410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location.</p>		<p>first month of employment. The Director of Health Services will use a check list for staff in the nursing department to be able to track the scheduling and completion of CPR and first-aid training. This tracking form will be monitored on a monthly basis.</p>	

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	<p>(B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature.</p> <p>Based on record review and interview, the facility failed to ensure the required dementia in-servicing was completed for 3 employees in a sample of 10. (Employee #20, Employee #21, Employee #24)</p> <p>Finding includes:</p> <p>On 4/29/15 at 2:05 P.M., review of the 10 employee files sampled indicated Employee #20, hired on 12/27/13, completed 6 hours of dementia training on 4/22/14, there was no documentation that Employee #20 completed the 3 hours of annual dementia training for 2015. Employee #21, hired on 10/18/13, completed 3 hours of dementia training on 4/3/14, there was no documentation that Employee #21 completed the 3 hours of annual dementia training. Employee #24, hired on 2/23/15, completed 6 hours of dementia training on 11/4/11 at his prior employment, there was no documentation that Employee #24 completed the 3 hours of annual dementia training for 2015 at his prior employment.</p>	R 120	<p><b>R 120 Personnel: Timely dementia training</b> The facility has interpreted the need for staff dementia training "per calendar year" as training that occurs at some point within the next calendar year, not necessarily within 12 months of the previous training. The three employees identified (#20, #21 <input type="checkbox"/>) as needing required dementia training have been scheduled to attend a dementia training class on May 19,2015. To our knowledge no residents experienced negative outcomes associated with this finding. All staff will be assessed as to whether they have required hours of dementia training within the specified time frames indicated in R120. Appropriate dementia training will be provided in timely way. Waterford Crossing will effectively become "The Residence at Waterford Crossing", a Trilogy-owned facility as of June 1, 2015. As such, Waterford Crossing will assume the Trilogy training guidelines and practices that ensure timely compliance within the regulatory dementia training requirements. Monitoring of dementia training and all other required training will be in accordance with the quality assurance practices of Trilogy</p>	06/19/2015			

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R 121  Bldg. 00	<p>During an interview, on 4/30/15 at 11:15 A.M., the Director of Nursing (DON) indicated Employee #20 and #21 should have 3 hours of annual dementia training completed, she further indicated Employee #24 had 3 hours of annual dementia training recently at his previous employer but had not brought the paperwork in to prove this. The DON indicated all 3 employees are scheduled to do their annual dementia training on 5/21/15.</p> <p>On 4/30/15 at 11:30 A.M., review of the current policy titled "Professional growth and Development" received from the DON indicated "...Continuing education and in-service training are important for maintaining high quality services. Therefore, all employees will be required to participate in education and training programs that will enhance their knowledge and personal skills. This training can include, but is not limited to, inservices...."</p> <p>410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of</p>		Health Services.				

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	<p>induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interview, the facility failed to ensure facility staff was given an annual tuberculin skin test for 1 of 10 sampled employees. (Employee #20)</p> <p>Finding includes:</p>	R 121	<b>R 121 Personnel: Staff TB skin test missed</b> A mantoux skin test was administered on April 30, 2015 to the one employee (#20) who was identified as not having a timely annual TB skin test. To our knowledge no residents experienced negative outcomes associated with this	06/19/2015

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R 214 Bldg. 00	<p>On 4/29/15 at 2:05 P.M., ten employee records were reviewed which indicated Employee #20's start date at the facility was 12/27/13, and the last annual tuberculin skin test was administered on 2/3/14 and read on 2/6/14.</p> <p>During an interview, on 4/30/15 at 11:10 A.M., the Director of Nursing (DON) indicated Employee #20 should have had an annual tuberculin skin test on 2/3/15 and it was not completed. The DON further indicated Employee #20 was scheduled to work evening shift tonight and would receive her tuberculin skin test before starting her work duties this evening.</p> <p>On 4/30/15 at 11:20 A.M., review of the current policy titled "Mantoux Testing Policy" received from the DON indicated "...All new employees will have a two-step mantoux test for tuberculosis and then be re-tested annually thereafter...."</p> <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.</p>		<p>finding. Staff records were reviewed to ensure that no other employees were out of compliance in regards to the required annual TB skin test. Waterford Crossing will effectively become "The Residence at Waterford Crossing", a Trilogy-owned facility as of June 1, 2015. As such, Waterford Crossing will assume the Trilogy compliance guidelines and practices related to TB skin testing that ensure timely compliance within regulatory requirements. Monitoring of staff and resident TB skin testing will be in accordance with the quality assurance practices of Trilogy Health Services.</p>				

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	<p>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 semi-annual evaluation for 1 of 7 resident's reviewed during clinical record reviews. (Resident #2)</p> <p>Finding includes:</p> <p>On 4/29/15 at 10:10 A.M., a clinical record review was conducted and indicated the resident had an initial evaluation on 9/5/14 and was documented on a form titled "Assistance Plan."</p> <p>During an interview, on 4/29/15 at 10:20 A.M., the Administrative Assistant indicated the resident was due the 1st of March for her semi-annual evaluation. She further indicated the evaluation had not been completed to date and the evaluation must of been missed.</p> <p>On 1/30/15 at 11:25 A.M., the Director of Nursing provided a policy titled, "Assisted Living Program," dated 5/2008, and indicated the policy was the one currently used by the facility. The policy indicated "...Prior to admission and at least semi-annually, a Functional Assessment will be completed...."</p>	R 214	<p><b>R 214 Evaluation: Missing semi-annual assessment of resident</b> Resident #2 has frequently been assessed by nursing staff due to the nature of her assistance needs. The formal semi-annual assessment, however, was not documented in accordance with regulations. An updated assessment was documented on her Assistance Plan as of May 1, 2015. To our knowledge this resident did not experience any negative outcomes associated with this finding. All residents have the potential to be impacted by untimely semi-annual assessments. As such, all Resident Assistance Plans were reviewed by May 22, 2015 to ensure that all are current and up-to-date. The Director of Health Services has assigned review of resident Assistant Plans to nurses on the first Wednesday of each month to ensure timely completion of semi-annual and/or as needed updated resident assessments. The Director of Health Services will review Assistance Plans on a monthly basis for compliant time-frames prior to the forms being filed in the residents' record. In addition, monitoring of resident records, including assessments, will be in accordance with the quality assurance practices of Trilogy Health Services.</p>	06/19/2015

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R 241  Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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>A. Based on observation, record review and interview, the facility failed to ensure PRN (as needed) medications were administered by licensed nursing personnel or a Qualified Medication Aide (QMA) for 2 of 4 residents reviewed for PRN medication administration. (Resident #2 and Resident #4)</p> <p>B. Based on record review, observation and interview, the facility failed to ensure physician orders were obtained for a medication that was dispensed three times a day to a resident. This had the potential to affect 1 of 5 resident's reviewed for medication administration. (Resident #23)</p> <p>Findings include:</p> <p>A.1. On 4/29/15 at 9:10 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the resident was admitted on 9/6/14. The residents diagnoses included but were not</p>	R 241	<p><b>R 241 Health Services: Medication Management</b></p> <p>A. PRN medication not administered by a QMA or nurse Resident #2 was assisted safely in self-administration of a PRN medication by a CNA in accordance with facility policy. While this resident has multiple medications, she was able to specifically request the PRN by name (a score of 30 out of 30 on her MMSE) and therefore was assisted in obtaining that specific medication, according to facility policy which had received prior ISDH approval. Regulatory definitions of "administration" and "assistance with self-administration" and references to practice continue to be interpreted by surveyors outside the scope of Assisted Living regulations, in our opinion. That being said, this facility continues to move toward staffing with QMAs or nurses on all shifts to ensure that residents receive safe and knowledgeable assistance with PRN medications. A recent recruiting ad was posted May 7, 2015 for</p>	06/19/2015			

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	<p>limited to: pulmonary embolism, diabetes, Parkinson's, hypertension, depression with anxiety and dementia.</p> <p>The initial Assistance Plan assessment, dated 9/5/14, indicated the resident would receive medications from the pharmacy in a pill pack and the nurse/QMA (Qualified Medication Aide) would administer her medications morning, noon, evening and bedtime.</p> <p>A pre-admission Medication Self Administration/Management Assessment, dated 8/31/14, indicated the resident was unable to "...Demonstrate an understanding of which medication can be taken "as needed" and what symptoms would indicate the need for the medication, and remember when they were taken last...." The assessment form further indicated the resident would receive "full medication administration services."</p> <p>The Admission Physical, dated 9/4/14, conducted by a local physician indicated the resident had fair short-term memory, fair long-term memory and fair judgement. The physician did not indicate the resident was capable of administrating her own medications.</p> <p>The Physician's Orders/Medication List</p>		<p>employment of nurses in our facility. Until that time, all requests for PRN medications that occur when there is not a nurse in the building will be directed to the nurse-on-call. The nurse-on-call will ensure that a QMA or nurse-on-call will provide the PRN medication for the resident. The PRN Tracking Form was revised to include the name of the nurse contacted and a place for a nurse signature to sign behind any PRN administration by a QMA (Attachment A). These Tracking Forms will be monitored for procedural compliance as part of the monthly medication QA audit conducted by the Director of Health Services. B. Missing physician order for a medication A physician order for Resident #23 was obtained on May 1, 2015 for the medication that the resident was receiving without a documented physician order. This over-the-counter medication was added to the "Over-The-Counter Medication Authorization" form for future opportunity for physician direction (Attachment B). To our knowledge this resident did not experience any negative outcomes associated with this finding. There is potential for any resident taking or receiving medications to be adversely impacted by taking medications outside the scope of a documented physician order. Medication reviews occur at</p>				

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	<p>for Resident #2 indicated the resident's PRN (as needed) medications included but were not limited to: alprazolam (anxiety) 0.5 mg (milligrams) three times a day as needed, MAPAP (Tylenol, pain) 500 mg. 1-2 tablets every 6-8 hours as needed and hydrocodone/APAP (acetaminophen) (pain) 7.5/325 mg. three times day as needed.</p> <p>A PRN Tracking Form for Norco (pain) 7.5/325 mg. (milligrams) one tablet po (orally) TID (three times a day) prn for Resident #2 indicated QMA # 3 had administered the medication on 9/15/14 at 8:00 P.M., and on 10/4/14 at 7:00 P.M. Another QMA #7 had given the Norco on 10/6/14 at 8:03 P.M. The form further indicated CNA#1 had administered Norco on 10/3/14 at 10:00 P.M. and CNA #8 had administered Norco on 10/6/14 at 8:42 P.M. The form did not contain a co-signature by an LPN or RN for the administered Norco.</p> <p>Another PRN Tracking form for alprazolam (Xanax) 0.5 mg TID (three times a day) indicated on 9/4/14 at 9:40 P.M., on 11/5/14 at 7:30 P.M. and 11/6/14 at 7:17 P.M., QMA #9 gave the alprazolam. On 12/7/14 at 1:30 A.M., CNA #5 gave the resident one pill. The form did not contain a co-signature by an LPN or RN.</p>		<p>several levels including physician direction and communication, pharmacy filling and dispensing, and nurse review of medications received in comparison with physician orders. The missed order represents human error and not necessarily a system that is not working. All medications are to be checked against physician orders on a routine basis. The Director of Health Services will randomly audit nurse medication check-ins from the pharmacy to ensure that Medication Administration Records are being reconciled with current physician medication orders. Waterford Crossing will effectively become "The Residence at Waterford Crossing", a Trilogy-owned facility as of June 1, 2015. Waterford Crossing will begin to receive medications and related services from the Trilogy-provided pharmacy (PCA), and follow best practices that ensure the safe administration and required documentation related to medications.</p>				

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	<p>A Daily Happenings form indicated the following:</p> <p>On 10/2/14 at 9:55 P.M., "...Res [resident] requested Xanax. This writer assisted Res[resident]...." signed by CNA #2.</p> <p>On 11/9/14 at 7:30 P.M., "...Res [resident] requested PRN Xanax, assisted with...." signed by QMA #4.</p> <p>On 11/12/14 at 7:05 P.M., "...Res[resident] asked for her "Lorazepam" xanax by name. This writer signed and gave her one...." signed by QMA#4</p> <p>On 12/7/14 at 1:30 A.M., "...Res [resident] requested xanax by name this writer assisted res [resident]with pill. Will check on one hour...." signed by CNA #5</p> <p>On 12/16/14 at 9:30 P.M., "...Res [resident] asked for Xanax by name at 9:25 pm. This writer gave her one...." signed by CNA #1</p> <p>On 1/5/15 at 12:00 A.M., "...resident called and asked for pill bottle on table this writer witnessed resident take one...." signed by CNA #6.</p> <p>On 1/9/15 at 7:30 P.M. "...2 pain med for pain per nurse...." signed by QMA #4.</p> <p>On 2/28/15 at 6:00 A.M., "Res [resident] was upset this writer called noc [nurse on call] who told to give res [resident] alprazolam 0.5mg...." signed by CNA #6.</p>			

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	<p>During an interview, on 4/29/15 at 10:20 A.M., the Administrative Assistant indicated a CNA can administer a medication to a resident if the resident requests the medication by name. The Administrative Assistant then provided a protocol for PRN medication assistance. The protocol indicated if the resident requested the PRN medication by "Specific Name" the following procedure was to be completed: "...1. You Do Not have to get NOC [Nurse on Call]/Nurse permission to assist with medication. 2. Assist res [resident] with medication. 3. Document on PRN tracking form in res [resident] room. 4. Document in DH [Daily Happenings] that medication was requested by name and that you assisted with the medication. 5. Go back in 1 hour and check on resident. If pill helped resident then great but if not then notify NOC/Nurse...."</p> <p>During an interview, on 4/29/15 at 10:30 A.M., the Director of Nursing (DON) indicated the CNA had access to the medications in the resident's room and Resident #2's medications were kept in a locked box in her room. The DON further indicated the resident would only have one days dose of PRN medications in the locked box the additional doses were kept in a lock box in the nurse's</p>			

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	<p>station. The DON further indicated the QMA's should have a nurse co-sign any PRN medications given by the QMA. The DON also indicated all PRN medications should be documented on the PRN Tracking Form and on the Daily Happenings form. The DON did not indicate a nurse was signing for the CNA administration for PRN medication as the resident had to request by name for the medication before the CNA would administer the medication. The DON indicated Resident #2 was evaluated to have medication administration services, however the resident could name her PRN medications. When asked about an entry on 10/2/14 resident requested Xanax and she said the CNA just wrote the wrong medication name on the Daily Happening form as the resident was never on Xanax. When asked about another entry on 11/12/14 when the resident requested lorazepam from the CNA, the DON indicated the resident was given her Xanax. Another entry on the Daily Happenings indicated on 1/9/15 at 7:30 P.M., the QMA gave 2 pain meds and the DON did not know if Tylenol or Norco was given as there was no entry for 1/9/15 at 7:30 P.M. on the PRN Tracking form for Tylenol or Norco.</p> <p>On 4/29/15 at 11:45 P.M., a current policy titled " Assistance with Self</p>			

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	<p>Administration of Medications" dated 8/2012 was received from the DON. The policy indicated "...Each resident will be assessed by the nurse as to their ability to self administer medications. The resident's physician will also indicate the resident's ability to self administer with staff support. The amount and type of assistance needed will be defined in the resident's assistance plan... When a resident requests a PRN medication, the nurse or nurse on call must be contacted, unless a specific medication is requested by name and assistance is no different than any other prescribed medication...."</p> <p>The policy did not address the co-signature of a licensed RN or QMA for PRN medication administration.</p> <p>During an interview on 4/30/15 at 1:45 P.M., the DON indicated staff were to document on the Daily Happenings form and on the PRN Tracking Form. The DON further indicated the staff did not check either form prior to administering PRN medications to check correct dosing or when last dose was administered.</p> <p>The Administrative Standards for the Indiana State Department of Health Nurse Aide Training Program, dated January 15, 2014, indicated under Standard 14 - Nurse Aide Scope of Practice "...The nurse aide will not</p>			

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	<p>administer any medications, perform treatments, or apply or remove dressings...."</p> <p>A.2. The clinical record for Resident #4 was reviewed on 04/29/15 at 11:00 A.M. Resident #4 was admitted to the facility on 12/09/11 with diagnoses, including but not limited to, arthritis, macular degeneration, depression, hypertension, and benign prostatic hypertrophy (BPH).</p> <p>The most recent Medication Self Administration/Management Assessment form, completed on 08/21/14, indicated the resident was dependent on staff to name, state the reason, or read the label on his prescribed medication, and was to receive full medication administration services. Although the assessment indicated he could not name, state the reason for his prescribed medications, or read the label for each medication, the assessment indicated with assistance he could demonstrate an understanding of which medications he could take "as needed" and the reason and timing of those medication.</p> <p>A "Daily Happenings" note, dated 06/22/14 at 6:50 P.M. indicated the following: "Res (resident) requested check temp. Temp - 100 % (degrees Fahrenheit). Res self-administered pain</p>			

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	<p>meds x 2. This writer let QMA (Qualified Medication Aide) on duty know." The note was signed by a CNA (Certified Nursing Assistant).</p> <p>During and interview with the Nursing Administrative Assistant, CNA #14, on 04/29/15 at 11:10 A.M. indicated if a resident could request the medication by name, then the CNA was allowed to obtain the medication from the locked box. She indicated the CNA was then to document the PRN medication on a "PRN tracking form." She retrieved a PRN tracking form from Resident #4's apartment, but the form was for "Xanax" (an antianxiety medication). There was no documentation or form for any type of pain medication. The QMA did not document being notified of the medication administration, which medication was given and the dosage given, and there was no authorization for the PRN medication documented by the licensed nurse.</p> <p>B.1. On 4/29/15 at 10:00 A.M., the clinical record for Resident #23 was reviewed. Resident #23 was admitted on 5/15/10 with diagnoses included, but not limited to: "...hypertension, rheumatoid arthritis, angioedema, chronic kidney disease stage II and dementia...."</p> <p>On 4/29/15 at 11:15 A.M., Qualified</p>			

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	<p>Medication Aide (QMA) #26 was observed to enter Resident #23's room who resided on the dementia unit and administered refresh eye drops 1 drop in each eye. The QMA indicated she dispenses the resident's medication due to her dementia and the eye drops really help her dry eyes.</p> <p>The "Daily Assistance Record" located in Resident #23's medication box indicated "...Refresh 1 gtt [drop] each eye at morning, noon and evening med [medication] administration...."</p> <p>On 4/30/15 at 10:00 A.M., review of Resident #23's physician orders indicated there was no physician order for the refresh eye drops. During an interview at that time, the Director of Nursing (DON) she indicated there was no physician order for the refresh eye drops. She further indicated she was unsure how long the resident had been using the eye drops.</p> <p>On 4/30/15 at 11:25 A.M., review of the current policy titled "Assistance with Self Administration of Medication" received from the DON indicated "...Any changes to the resident's drug regimen will be managed by the physician, nurse and pharmacist...."</p>			

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R 246  Bldg. 00	<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 observation, record review, and interview the facility failed to ensure PRN (as needed) medications were authorized by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) prior to being administered by a Qualified Medication Aide (QMA) during 2 of 7 resident's clinical record reviews. (Resident #2 and Resident #47)</p> <p>Findings include:</p> <p>1. On 4/29/15 at 9:10 A.M., a review of the clinical record for Resident #2 was conducted. The record indicated the resident was admitted on 9/6/14. The residents diagnoses included but were not limited to: pulmonary embolism, diabetes, Parkinson's, hypertension, depression with anxiety and dementia.</p> <p>On 4/29/15 at 9:30 A.M., the Physician's</p>	R 246	<p><b>R 246 Health Services: Failure to gain nurse authorization for PRN medication</b> Two residents were identified (#2 &amp; #47) who received PRN medications from a facility QMA without having the subsequent co-signature of a nurse, therefore implying that a nurse did not give permission for the medication to be administered. While no harm to the residents were observed, the lack of a nurse co-signature following QMA administration is outside of the facility protocol and QMA scope of practice. All residents can potentially receive PRN medications from a QMA and not have the required permission or evidence of permission by way of a nurse co-signature. The "PRN Tracking Form" was revised to more clearly indicate where the required nurse co-signature is needed (Attachment A). QMAs and</p>	05/22/2015			

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	<p>Orders/Medication List for Resident #2 indicated the resident's PRN medications included but were not limited to: alprazolam (anxiety) 0.5 mg (milligrams) three times a day as needed, MAPAP (Tylenol, pain) 500 mg. 1-2 tablets every 6-8 hours as needed and hydrocodone/APAP (acetaminophen) (pain) 7.5/325 mg. three times a day as needed.</p> <p>A PRN Tracking Form for Norco (pain) 7.5/325 mg. (milligrams) one tablet po (orally) TID (three times a day) as needed prn for Resident #2 indicated QMA # 3 had administered the medication on 9/15/14 at 8:00 P.M., and on 10/4/14 at 7:00 P.M. Another QMA #7 had given the Norco on 10/6/14 at 8:03 P.M. The form did not contain a co-signature by an LPN or RN for the administered Norco.</p> <p>Another PRN Tracking form for alprazolam (Xanax) 0.5 mg TID (three times a day) as needed for Resident #2 indicated on 9/4/14 at 9:40 P.M., on 11/5/14 at 7:30 P.M. and on 11/6/14 at 7:17 P.M., QMA #9 gave the alprazolam. The form did not contain a co-signature by an LPN or RN.</p> <p>Another PRN Tracking form for Tylenol 500 mg give 1-2 tablets every 6-8 hours as needed for Resident #2 indicated</p>		<p>nurses were informed on May 18, 2015, of the revised "PRN Tracking Form" and the following new written procedure, "QMA Protocol for Administration of PRN Medications": 1. PRN medications may be administered by a QMA only upon authorization by a nurse. 2. Authorization from the nurse is required prior to each administration of a PRN medication. 3. All contacts with a nurse not on the premises shall be documented in the nursing notes indicating the time and date of the contact. 4. Verification of nurse permission is required byway of the contacted nurse's co-signature on the PRN Tracking Form. 5. Follow-up QMA documentation within one of hour of administration of a PRN medication is required to assess effectiveness ofthe PRN medication upon the resident. The PRN Tracking Form was revised to include the name of the nurse contacted and a place for a nurse signature to sign behind any PRN administration by a QMA (Attachment A). These Tracking Forms will be monitored for procedural compliance as part of the monthly medication QA audit conducted by the Director of Health Services.</p>				

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	<p>QMA #9 gave 2 tablets on 1-5-15 at 7:00 P.M., 1 tablet on 2/6/15 at 8:00 P.M., and one tablet on 4/2/15 at 3:00 P.M.</p> <p>The form did not contain a co-signature by an LPN or RN.</p> <p>A Daily Happenings form indicated the following: On 10/4/15 at 7:00 P.M., "...Res [resident] requested Pain med by name "Norco" given by this writer....", signed by QMA #3 On 11/9/14 at 7:30 P.M., "...Res [resident] requested PRN Xanax, assisted with...." signed by QMA #4. On 11/12/14 at 7:05 P.M., "...Res[resident] asked for her "Lorazepam" xanax by name. This writer signed and gave her one...." signed by QMA #4 On 1/9/15 at 7:30 P.M., "...2 pain med for pain per nurse...." signed by QMA #4. On 4/2/15 at 3:00 P.M., "...This writer assisted resident with PRN pain medication c/o [complains of] pain will recheck for effectiveness in 1 hr [hour]...." signed by QMA #9. The form did not contain a co-signature by an LPN or RN for the above PRN medications administered by the QMA.</p> <p>During an interview, on 4/29/15 at 10:30 A.M., the Director of Nursing (DON) indicated the QMA's should have a nurse</p>			

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R 273 Bldg. 00	<p>co-sign any PRN medications given by the QMA. The DON further indicated if the resident requested the PRN medication by name the QMA did not have to contact the nurse, regardless if the facility was responsible for administering the resident's medications per physician's order or facility's medication self administration assessment. The DON confirmed the resident had no orders to receive Xanax or Lorazepam.</p> <p>2. On 4/30/15 at 10:31 A.M., Resident #47's PRN tracking form indicated Norco 5/325 mg. one tablet was given on 4/25/15 at 8:05 P.M., by QMA #9. The form did not contain a co-signature by an LPN or RN.</p> <p>A policy was requested from the DON regarding the QMA's responsibilities, however one was never received from the facility.</p> <p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review and interviews, the facility failed to ensure</p>	R 273	<b>R 273 Food and Nutritional Services: Sanitary preparation</b>	05/19/2015			

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	<p>food was prepared and served in a sanitary manner in 1 of 1 kitchen and 2 of 3 dining rooms. This potentially affected 45 of 45 residents who consumed food in the facility.</p> <p>Findings include:</p> <p>1. During observation of the kitchen, conducted on 04/28/15 from 10:30 A.M. - 10:45 A.M., the following was noted:</p> <p>There was a trash can, not utilized during the observation, placed in front of the grill in the food preparation area, 3/4 full of refuse, not covered. Cook #10 was on a break for most of the observation and Cook #11 was not observed to actively be utilizing the trash can.</p> <p>During observation of the kitchen during food service, conducted on 04/28/15 from 11:15 A.M. - 12:00 P.M., the following was noted:</p> <p>The trash can, previously noted uncovered, remained in the same position. Cook #10 and #11 were setting up for the meal service and were not observed to continually need to throw trash away during the observation. Cook #11, who was preparing soups, short order foods, and mashed potatoes and gravy was noted to occasionally throw</p>		<p><b>and service of food</b></p> <p>A. <u>Uncovered trash receptacle</u> In reference to 410 IAC 7-24 which states, "Receptacles and waste handling units for refuse, recyclables, and returnables shall be kept covered: inside the retail food establishment if the receptacles and units: contain food residue and are not in continuous use." It is our opinion that the receptacle was in continuous use during the time of meal preparation and did not pose a threat toward food contamination in any way. To our knowledge no residents experienced negative outcomes associated with this finding. A receptacle with a lid has been secured and will be utilized for future times of meal preparation to meet the interpretation expectations of the survey team. The Executive Director, as a member of the Infection Prevention Committee, met with Food Service staff on May 18, 2015 to offer training on when trash receptacles need to be covered with a lid in accordance with 410 IAC 7-24-392. Compliance will be monitored by the Food Service Assistant Manager by way of random checks at both the noon and evening meal service times. Completion date: May 19, 2015</p> <p>B. <u>Unsanitary use of gloved hands</u> Cooks #10 &amp; #11 were observed touching various objects and then handling food or</p>	

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	<p>trash into the trash can.</p> <p>Cook #11 was observed to have gloves on both her hands. She was noted handle the oven door, stir gravy, then ladle onion soup into mugs, wipe off mugs with a damp rag, and then handled the outside of a large bag of french fried onions. She reached into the bag with her contaminated gloved hand, grabbed a small handful of onions and proceeded to sprinkle the onions over the top of the mugs of soup.</p> <p>Cook #10 who was wearing gloves, was noted to remove a large pan of pizza from the oven. She then proceeded to slice the pizza with a pizza cutter. She then, without removing or changing her gloves, proceeded to transfer the large pizza slices from the pan to the steam table. She utilized a spatula but was noted to hold the large slices onto the spatula by touching each slice on the crust with her contaminated gloved hand.</p> <p>Cook #11, was noted to change her gloves, handle the outsides of packages of buns and muffins and lay them onto the counter. She then handled the oven door to retrieve a serving of mashed potatoes, handled the door to the salad cooler, and wiped the outside edge of her nose. Then, without changing her gloves,</p>		<p>clean dishes without changing gloves when there was potential for contamination due to what had been touched. While there is no evidence of any negative resident outcomes associated with this finding, proper sanitary technique is critical to lessen the opportunity for contamination of any kind. All residents who eat foods prepared or served in unsanitary conditions could experience adverse outcomes. The Executive Director, as a member of the Infection Prevention Committee, met with Food Service staff on May 18, 2015 to offer training on proper use of gloves and the limitations of perceived "glove safety" in accordance with 410 IAC 7-24-246 which states if used, single-use gloves shall be:</p> <ol style="list-style-type: none"> <li>1. Used only for one task, such as working with ready-to-eat food or with raw animal food;</li> <li>2. Used for no other purpose; and</li> <li>3. Discarded when damaged or soiled, or when interruptions occur in the operation</li> </ol> <p>Compliance will be monitored by the Food Service Assistant Manager by way of random checks at both the noon and evening meal service times. Completion date: May 19, 2015</p> <p>C. <u>Effectiveness of hair restraint</u> Wait staff and dietary staff were observed to be in and out of the kitchen to obtain food to carry out to the residents' eating areas. They are instructed to have long hair tied back to prevent hair from</p>				

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	<p>she opened a large bag of potato chips and reached into the bag, obtained a large handful of chips and placed them onto a plate. Then Cook #10, who had sifted through a few paper menu orders, placed a piece of pizza onto the plate and utilized her contaminated gloved hand to move the chips over to accommodate the chips.</p> <p>Cook #11 was also noted to hold a piece of grilled chicken with her contaminated gloved hands while she checked the temperature of the chicken. Prior to touching the chicken she was noted to touch oven doors, the outside of a pan, a pair of tongs, paper menus, and the handles of ladles.</p> <p>During the course of the observation, wait staff and 2 dietary staff members were noted to enter from the green dining room door, walk across and into the kitchen to the steam table pan, reach into a cooler type refrigerator to retrieve small bowls of salads, which were uncovered, all while having their hair uncovered. In addition, Wait staff #12 and #13 were noted to take plates of food out into the green dining room, serve the food, pick of empty dishes off of tables after residents ate their salads and soups, place the dirty dishes on a cart located approximately 6 feet inside the kitchen,</p>		<p>interfering with sanitary food service. Cooks wear hair coverings as instructed. In accordance with 410 IAC7-24-138, wait staff and dietary staff will be monitored to comply with appropriate cautionary measures aside from wearing hair restraints (as do the cooks). As stated in this regulation, "This section does not apply to food employees, such as counter staff who only serve beverages and wrapped or packaged foods, hostesses, and wait staff, if they present a minimal risk of contaminating: exposed food, clean equipment, utensils and linens, unwrapped single-service and single-use articles." The Executive Director met with Food Service staff on May 18, 2015 to review the findings of the survey team in relation to appropriate caution for hair not to come in contact with any of the items mentioned in 410 IAC 7-24-138. Compliance will be monitored by the Food Service Assistant Manager by way of random checks at both the noon and evening meal service times. Completion date: May 19, 2015 D. <u>Hand Sanitation</u> Wait staff and dietary staff were observed to be in and out of the kitchen to obtain food to carry out to the residents' eating areas while carrying back dirty dishes to the kitchen without washing hands after handling the dirty dishes. To</p>	

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	<p>then proceed another 6 - 7 feet to the food preparation/steam table area and obtain more food for service. They were not observed to wash their hands and their hair was not covered. Wait staff #12 was noted to cut up meatballs for a resident and reach into the cooler to obtain an uncovered salad, all without washing her hands or having her hair covered. In addition, Dietary staff member #14, who had been serving food, going from the kitchen into the dining room and back was noted to go over to the dishwasher and proceeded to wash dishes. She was not wearing a hair covering and she did not wash her hands.</p> <p>Review of the current facility policies and procedures, provided by the Administrator on 04/29/15 at 9:10 A.M., titled "Infection Control and Illness Response Plan, included the following: "...Frequent hand washing for the duration of 15 seconds.[sic] Hand washing is the most important method of infection control Hands must be washed between direct contact with any residents, after doing cleaning tasks, after using the restroom or any other task that provides opportunity for infection...Gloves will be worn by staff when coming in contact with blood or body secretions, when working with kitchen food preparation, and in</p>		<p>our knowledge no residents experienced negative outcomes associated with this finding. All residents could potentially be negatively impacted by the lack of hand washing or ineffective hand washing. The tasks of serving food and clearing off dirty dishes were revised so that one person is responsible for clearing the dirty dishes off tables while the others are only bringing out the clean, plated dishes. The Executive Director met with Food Service staff on May 18, 2015 to review the findings of the survey team in relation to hand washing and to provide training on 410 IAC 7-24-129, "When to wash hands" that includes specific instructions for food service staff to attend to. The Director of Health Services will instruct staff in the dementia unit on when and how gloves should be utilized when serving residents food in that location to maintain a sanitary approach to food service. Compliance will be monitored by the Food Service Assistant Manager (kitchen) and by the Director of Health Services (dementia area) by way of random checks at both the noon and evening meal service times. Completion date: May 19, 2015</p>	

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	<p>situations where universal precautions apply...." The Administrator also provided policies and procedures on the procedures of handwashing and changing gloves, and a generic policy on infection control, however, there were no specific dietary policies regarding glove use, food handling, and handwashing specific to the kitchen.</p> <p>During an interview on 4/29/15 at 11:34 A.M., the Administrator indicated he did not feel the uncovered hair was a concern regarding the noon meal service because it was servers in the kitchen with uncovered hair. He also indicated the uncovered trash can was not a concern because it was in continual use.</p> <p>2. On 4/28/15 between 12:00 P.M.-12:25 P.M., the following was observed during the dining service in the dementia unit:</p> <p>CNA #25 washed her hands at the sink for 20 seconds then turned the faucet off her her clean bare hands, she then dried her hands with a paper towel. QMA #26 washed her hands for 12 seconds, donned a pair of gloves then opened 3 separate drawers with her gloved hands and searched through each drawer for serving spoons. QMA #26 opened the refrigerator door with her gloved hands looking for salad dressing. She then prepared 2 plates of food to take around to each resident</p>			

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R 301 Bldg. 00	<p>and asked what they preferred to eat. QMA #26 then assisted CNA #25 and prepared each resident's plate and delivered it to each resident, her gloved fingers were touching the inside of the plates and the food. As she delivered each resident's plate she touched the back of their chairs with her gloved hands. QMA # 26 was not observed to change her gloves during the entire meal service.</p> <p>On 4/28/15 at 12:30 P.M., QMA #26 was observed to remove her gloves and place them in the trash can located under the sink, she then removed the trash can from under the sink and took the trash bag out of the container. After QMA #26 removed the trash bag from the container she was not observed to wash her hands, and proceeded to collect the salad bowls off the table from each resident.</p> <p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription.</p>			

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	<p>If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation and interview, the facility failed to document an open date on multi-dose vials of an influenza vaccine and of Tubersol (medication for the tuberculin test) and was unable to confirm the vials had not expired, during 1 of 1 medication room observations.</p> <p>Finding includes:</p> <p>On 4/29/15 at 2:25 P.M., an observation of the medication storage in the nursing office was conducted with the Director of Nursing (DON). The medication refrigerator contained two open vials. One vial contained a multi-dose influenza vaccine and the other multi-dose vial contained Tubersol. Neither vial had an open date on the vial. The Tubersol stated on the box "...A vial of Tuberculin PPD [Purified Protein Derivative] which has been entered and in use for 30 days must be discarded..." The DON indicated the vials were received from the pharmacy sometime in the fall of 2014 and the Tubersol had been used for resident's and personnel as recent as this week, on Monday (4/27/15). She could not confirm if the vial had been open for more or less than 30 days. The DON indicated the influenza vial had not been</p>	R 301	<p><b>R 301 Pharmaceutical Services: Open date missing on multi-dose vials A</b></p> <p>Flu vaccine multi-dose vial and a Mantoux solution multi-dose vial were both found in the medication refrigerator without an open date label, therefore not allowing nurses to know when the medications were beyond their intended shelf life. To our knowledge no residents or staff experienced negative outcomes associated with this finding. The two multi-dose vials were discarded when it was determined that they had likely been opened beyond the 30-day expiration period. Labels for indicating open dates were made available for nurses who open a new vial to date appropriately. The Director of Health Services met with nurses on May 20, 2015, to review the need to place these labels on opened multi-dose vials. The Director of Health Services will conduct a weekly audit of the Medication Room and refrigerator to ensure that the open vials are dated appropriately and that expired medications are removed and discarded.</p>	05/20/2015

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R 304 Bldg. 00	<p>used since last fall.</p> <p>On 4/29/15 at 3:20 P.M., the DON indicated the facility had no policy or procedure for multi-dose vials. The DON further indicated she had contacted their pharmacy representative and the influenza vial should have been discarded 30 days after opening and all multi-dose vials should be labeled with an open date when used the first time.</p> <p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation, record review, and interview the facility failed to secure Schedule II medications, the facility administered, in a double locked container for 2 of 4 residents reviewed for narcotics in their rooms. (Resident #2 and Resident #47)</p> <p>Findings include:</p> <p>1. On 4/29/15 at 9:30 A.M., the Physician's Orders/Medication List for Resident #2 indicated the resident's PRN</p>	R 304	<p><b>R 304 Pharmaceutical Services: Lack of a double-lock on Schedule II medications</b> The two residents (#2 &amp; #47) who lacked a double-lock to secure their Schedule II medications received a securely locked box on May 1,2015 for the Schedule II PRN medications, within the larger second-locked medication box in their apartment. To our knowledge no residents experienced negative outcomes associated with this finding. All residents were reviewed for the</p>	05/22/2015

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	<p>(as needed) medications included but were not limited to: alprazolam 0.5 mg (milligrams) three times a day as needed, and hydrocodone/APAP (acetaminophen) 7.5/325 mg. three times day as needed.</p> <p>On 4/29/15 at 3:05 P.M., Resident #2's apartment door was observed to be open, with a wooden door jam.</p> <p>On 4/30/15 at 9:00 A.M., the resident's door was observed with LPN #10 opened with a wooden door jam. LPN #10 indicated the resident keep their door open most of the time. LPN #10 was observed to go to closet door just inside the door and take out a plastic medication box. The box had no lock on it. LPN #1 opened the plastic box and pulled out a bottle labeled with hydrocodone/APAP 7.5/325 mg., dated 8/23/14, for 90 tablets.</p> <p>On 4/30/15 at 9:50 A.M., an observation of the plastic medication box for Resident #2, with the DON, indicated the medication was not in a locked box/plastic container.</p> <p>On 4/30/15 at 10:15 A.M., the DON was observed counting the number of hydrocodone/APAP located in the resident's room. The count was conducted by the DON and indicated</p>		<p>presence of Schedule II medications in their medication box. No other residents were impacted by lack of a double-lock for Schedule II medications. The Director of Health Services revised the "Daily Assistance Record" (Attachment C), to include the Schedule II PRN medications on the form which will ensure that these medications are reconciled each shift to ensure accuracy in the management of these medications. The Director of Health Services met with nurses on May 20,2015, to review the revised "Daily Assistance Record" which included instruction on the reconciliation of any Schedule II medications. The Director of Health Services will audit the Daily Assistance Records that contain Schedule II medications on a weekly basis for 4 weeks, then every quarter.</p>				

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	<p>there were 41 tablets.</p> <p>2. On 4/30/15 at 8:50 A.M., the Physician's Orders/Medication List for Resident #47 indicated the resident's PRN medications included, but were not limited to: norco 5/325 mg. one tablet every 4 to 6 hours as needed for pain.</p> <p>On 4/30/15 at 9:56 A.M., the DON was observed knocking at Resident #47's door, then taking a key and opening the door. The resident and her husband were in their apartment. The resident's medication/plastic box was on a table, with no lock on it. The resident's medication box contained a bottle labeled hydrocodone 5/325 mg. (same as norco) dispensed, on 4/23/15, 20 tablets. The DON counted 12 tablets in the bottle. The DON indicated the facility administered Resident #47's medications. The DON further indicated the Schedule II narcotics were not being reconciled by being counted daily, on each shift, by nursing personal for resident #2 or Resident #47. Reconciliation was done to verify the medication count and amount given to the resident. The DON indicated she was unaware those resident's had so many narcotics in their room.</p> <p>On 4/30/15 at 10:30 A.M., the Administrator indicated he was unaware</p>						

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	<p>of Schedule II medications not being double locked.</p> <p>On 4/30/15 at 2:30 P.M., a list of "Controlled Substances" was received from the DON who indicated their pharmacy faxed the list to them. The list indicated on page 8, hydrocodone was a Schedule II narcotic.</p> <p>During a telephone interview on 4/30/15 at 2:25 P.M., the facility's Pharmacist indicated he was unaware Schedule II medications were not secured in a double locked box in the facility.</p> <p>On 4/30/15 at 2:30 P.M., the DON provided a policy titled "Medication Storage", dated 7/2013, and indicated the policy was the one currently used by the facility. The policy indicated "...4. All Schedule II drugs administered by the facility will be kept in a locked container inside another locked medication storage closet or mobile storage unit, ensuring that a double-lock system is in place...."</p>			