

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155635	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2016
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NAME OF PROVIDER OR SUPPLIER GRACE VILLAGE HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 337 GRACE VILLAGE DR WINONA LAKE, IN 46590
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00205983.</p> <p>Complaint IN00205983 - Substantiated. Federal/State deficiency related to the allegation is cited at F333.</p> <p>Survey dates: August 29 and 30, 2016</p> <p>Facility number: 000501 Provider number: 155635 AIM number: 100266260</p> <p>Census bed type: SNF: 7 SNF/NF: 68 Residential: 53 Total: 128</p> <p>Census payor type: Medicare: 6 Medicaid: 47 Other: 22 Total: 75</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
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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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F 0333 SS=D Bldg. 00	<p>QR completed by 11474 on August 31, 2016.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure medications were administered in a timely manner for 2 of 4 residents reviewed (Resident B and Resident C). The facility also failed to administer PRN (as needed) medication as ordered by a physician for 1 of 4 residents reviewed (Resident B).</p> <p>Findings include:</p> <p>1. The closed clinical record for Resident B was reviewed on 8/29/16 at 10:15 a.m. Diagnoses included, but were not limited to, aphasia, chronic atrial fibrillation, acute kidney disease, heart disease and post thoracentesis.</p> <p>Review of the Medication Administration Record (MAR) for July 2016, Resident B received the following medications on July 21, 2016 at 2:53 p.m.:</p> <p>a. Florinef (corticosteroid medication) 0.1 mg- ordered 6/8/16. b. Coreg (a medication used to treat</p>	F 0333	<p>I. <u>Corrective action taken for affected residents:</u> No corrective action could be taken for resident B as this was a closed chart. Resident C was assessed for any adverse effects and is medically stable.</p> <p>II. <u>How other residents potentially affected will be identified:</u> A review of all residents found no others to have had adverse effects related to medication administration.</p> <p>III. <u>Measures implemented to ensure deficiency does not recur:</u> Analysis showed the primary problem was time management of nurses responsible for passing meds. Immediate steps that have been taken to allow for med passes to be completed in a timely manner include: 1) The unit secretary will manage all incoming phone calls and take messages so that nurses are not frequently distracted unless it is a physician call or emergency. 2) When unexpected events require the attention of a nurse</p>	09/29/2016

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	<p>hypertension) 6.25 mg- ordered 6/9/16. c. Vitamin D 2000 Units- ordered 6/9/16. d. furosemide (diuretic medication) 40 mg (2 tablets)- ordered 6/21/16. e. aspirin (atrial fibrillation medication) 325 mg- ordered 6/8/16. f. docusate (stool softener medication) 100 mg -ordered 6/8/16. g. magnesium 100 mg- ordered 6/8/16. h. potassium chloride (diuretic medication) ER 20 mEq- ordered 6/8/16. i. tamsulosin (Benign prostatic hyperplasia medication) 0.4 mg- ordered 6/8/16. j. Coenzyme Q10 100 mg- ordered 6/8/16.</p> <p>Review of the physician orders for the medication listed, indicated all the medication was to be given after breakfast.</p> <p>An order, dated 7/26/16, indicated potassium chloride ER 20 mEq to be given three times daily; after breakfast, after lunch and after supper. The medication was given on 7/26/16 at 1:31 p.m. and again at 1:46 p.m.</p> <p>Review of a physician order, dated 7/5/16, indicated metolazone (diuretic medication) 5 mg daily as needed for a weight gain of 2 lbs or more was to be given.</p> <p>Review of the July weights for Resident B, indicated on 7/13/16, a weight of 132.6 lbs was obtained and on 7/14/16, a</p>		<p>during the med pass, the nurse manager will either step in to complete the med pass or address the unexpected event.</p> <p>3) Med pass times will be reviewed periodically by the nurse manager to ensure that the number of meds to be passed and number of residents per unit is manageable in the allowable time frame and based on resident wake up times.</p> <p>The second concern regarding medications being administered per physician orders has been identified to be a system flaw. Weights were recorded in a different location in the electronic charting system from where the physician orders are written on the MAR. The system has been modified so that weights are now entered on the MAR and attached to the PRN order. (See attachment A) If the weight is not entered, it will show on an exception report and prompt the nurse to obtain the weight. All nurses will be in-serviced on the updated policy and procedure. (See attachment C)</p> <p><u>IV. How corrective measures will be monitored:</u> The DON and the team of nurse managers will conduct chart audits on 50% of the residents on each unit each week for a minimum of 60 days. A monitoring tool has been created on which med pass times will be recorded and checked against</p>	

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	<p>weight of 134.6 lbs was obtained. On 7/17/16, a weight of 134.0 lbs was obtained and on 7/18/16, a weight of 137.0 lbs was obtained. On 7/26/16, a weight of 144.0 lbs was obtained and on 7/27/16, a weight of 146.0 lbs was obtained.</p> <p>Review of the MAR for July 2016, Resident B did not receive metolazone as ordered. No additional documentation was provided.</p> <p>During an interview on 8/29/16 at 2:50 p.m., the Assistant Director of Nursing indicated she could not find any additional information related to the metolazone being given. She indicated it may have been a nursing judgement, but "they [staff] cannot override a physician's order."</p> <p>Review of a current health care plan dated 6/8/16, indicated Resident B had a problem with fluid volume deficit related to the use of diuretic and fluid restriction. Interventions included, but were not limited to, "...assess weights....Administer medications per physician's order....Notify physician of any side effects or if not effective."</p> <p>2. The clinical record for Resident C was reviewed on 8/30/16 at 10:11 a.m. Diagnoses included, but were not limited to, ischemic cardiomyopathy, neoplasm of upper left lobe and chronic obstructive pulmonary disease.</p>		<p>the acceptable med pass time frame. (See attachment B) The DON, or her designee, will also review the charting of Lasix administration per physician ordered parameters according to the same monitoring schedule. If compliance is found to exceed 95%, the monitoring frequency may be continued on a monthly basis, but for a minimum of 6 months. The results of this active monitoring will be reported to the QA Committee. The committee will prescribe further corrective measures and monitoring if compliance is not maintained at a minimum of 95%.</p> <p>Administration requests paper compliance on this plan of correction.</p>	

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	<p>During an interview on 8/30/16 at 9:35 a.m., Resident C indicated he did not receive his medications on time. He indicated some nurses do a better job than others with time management.</p> <p>Review of the Medication Administration Record for August 2016, Resident C received potassium chloride ER 20 mEq (2) tablets on August 26, 2016 at 2:11 p.m. and again at 2:14 p.m. Resident C received the same medication on 8/29/16 at 2:17 p.m. and again at 2:17 p.m.</p> <p>Review of the physician orders, dated 8/22/16, indicated the medication was to be given three times daily; after breakfast, after lunch and after supper.</p> <p>Review of a current health care plan, dated 6/21/16, indicated Resident C had a problem with alteration in fluid maintenance related to pulmonary edema. Interventions included, but were not limited to, "Administer medications per physician's order....report any signs of edema that is unresolved."</p> <p>Review of a current undated facility policy titled "MEDICATION ADMINISTRATION PROCEDURE," which was provided by the Director of Nursing on 8/29/16 at 1:45 p.m., indicated the following: "Purpose: To ensure that residents receive medications as ordered. Policy: All medications will be administered as ordered and documented.</p>			

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	<p>Medication Administration [sic] is per residents routine and/or schedules.</p> <p>Procedures:</p> <p>1. Confirm that the physician's order matches the MAR....</p> <p>...10. Always document/initial that medication was given (or refused) after each resident...."</p> <p>This Federal tag relates to Complaint IN00205983.</p> <p>3.1--25(b)(9)</p>			