

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155742	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/04/2015
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NAME OF PROVIDER OR SUPPLIER  ST ANDREWS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 LAMMERS PIKE BATESVILLE, IN 47006
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: August 31, September 1, 2, 3, and 4, 2015</p> <p>Facility number: 004671 Provider number: 155742 AIM number: 200538760</p> <p>Census bed type: SNF: 12 SNF/NF: 41 Residential: 34 Total: 87</p> <p>Census payor type: Medicare: 13 Medicaid: 18 Other: 22 Total: 53</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR was completed by 34849 on September 11, 2015.</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 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the MDS (Minimum Data Set) assessments were accurate for 1 of 17 residents reviewed for MDS.</p>	F 0278	<b>Res #77 was discharged from the campus on 5/28/15. A modified assessment was completed to reflect an accurate MDS assessment of no open areas for resident # 77</b>	10/04/2015

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	<p>Findings include:</p> <p>Resident #77's clinical record was reviewed on 09/02/2015 at 1:34 P.M. The PPS (Prospective Payment System) 5-day MDS assessment, dated 04/01/2015, indicated the resident had a Stage II pressure ulcer. The PPS 14-day MDS assessment, dated 04/08/2015, indicated the resident had a Stage II pressure ulcer. The PPS 30-day MDS assessment, dated 04/22/2015, indicated the resident had a Stage II pressure ulcer. The PPS 60-day MDS assessment, dated 05/20/2015, indicated the resident had a Stage II pressure ulcer. The Discharge MDS assessment, dated 05/29/2015, indicated the resident had no pressure ulcers.</p> <p>The "Nursing Admission Assessment &amp; Data Collection", dated 03/25/2015, indicated an open area on Resident #77's left buttock.</p> <p>During an interview on 09/03/2015 at 2:03 P.M., RN #3 indicated Resident #77 did not have a pressure ulcer when he was admitted on 03/25/2015. She further indicated the admission assessment was incorrect.</p> <p>During an interview on 09/04/2015 at 9:47 P.M., the MDS Coordinator indicated the MDS assessments for</p>		<p><b>on 9/4/15. This was conducted by the MDS support nurse. All residents whorequire completion and submission of the Minimum Data Set had the potential to be affected by the practice. The campus MDS Coordinator was re educated on the RAI manual for proper coding of MDS on 9/4/15. This was completed by the MDS Support Nurse. MDS Coordinator with Clinical Support audited 672 who were triggered as having pressure ulcers to insure accurate coding of those identified residents.. In addition, all licensed staff were re-educated on accurate completion of the nursing admission assessment, with emphasis placed on the area of skin impairments. This was conducted by the DHS/Unit Manager/ADHS on 9/8/15. Nursing Inservice with PCA Pharamcy representative scheduled for 9/23/15. MDS Coordinator, DHS , ADHS and nurse manager will audit 5 nursing admission assessments weekly x 4 weeks, then 3 weekly x 4 weeks, then 1 weekly x 4 weeks. MDS Coordinator, DHS, ADHS, Nurse manager will audit 3 MDS's for accurate coding weekly x 4 weeks, then 3 x 4 weeks, 2 x 4 weeks, Then 1 monthly x 3 months. The MDS support nurse will review a minimum of 2 MDS'S</b></p>		

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	<p>Resident #77 were incorrect and the resident did not have a pressure ulcer. She further indicated that she believed the mistake was made because Resident #77 previously had a Stage II pressure ulcer documented in his clinical record, the resident had been discharged on 03/21/2015 and the old documentation remained in the record, unchanged after his readmission on 03/25/2015.. The MDS Coordinator indicated she would normally go with the nurse during the review period to see the resident's skin before entering the assessment data, but that she does not remember doing that for Resident #77.</p> <p>During an interview on 09/04/2015 at 9:50 A.M., the Assessment Support Nurse indicated that with the MDS assessment, resident information can be copied forward from the previous assessment and then issues can be resolved. She indicated that the documentation noting a pressure ulcer may not have gotten removed when this was done for Resident #77.</p> <p>During an interview and record review on 09/04/2015, the Assessment Support Nurse indicated the MDS Coordinator follows the RAI (Resident Assessment Instrument) manual and provided the current manual, dated October, 2014. The</p>		<p><b>during routine visits to insure ongoing compliance. Results of these findings will be presented and reviewed in monthly QAA meetings. If any areas of concerns are identified action plans will be developed and continue until substantial compliance is achieved.</b></p>	

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F 0282 SS=D Bldg. 00	<p>manual indicated, "...each MDS assessment accurately reflects the resident's status..., ...the assessment process includes direct observation, as well as communication with the resident and direct care staff on all shifts..."</p> <p>3.1-31(g)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure physician's orders were followed related to monitoring and documenting of blood pressure and blood sugar for 1 of 5 residents reviewed for medication orders. (Resident #11)</p> <p>Findings include:</p> <p>The record review of a significant change MDS (Minimum Data Set) Assessment dated 02/17/2015, on 09/03/2015 at 11:00 A.M., indicated Resident #11 had diagnoses including, but not limited to, hypertension and diabetes.</p>	F 0282	<p><b>Resident #11's doctor was notified immediately by the licensed nurse of the lack of documentation of blood pressures and blood sugars on the MAR, and no new orders were received. Resident # 11 was re-assessed by the nurse to include blood pressure reading and assessment of signs and or symptoms of hyper or hypo glycemia. Resident did not have any adverse affects from documentation omissions. All residents receiving antihypertensives with physician orders for parameters of administration and physician orders for blood sugarlevels. had the potential</b></p>	10/04/2015

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	<p>The current care plan was provided by the MDS Coordinator on 09/02/2015 at 10:20 A.M. The care plan indicated Resident #11 had diabetes and "My nurse should administer my medications as ordered." The care plan also indicated the resident had hypertension and to "Please administer my medications as ordered."</p> <p>The physician's admission order dated 04/15/2015, indicated Novolog insulin should be given prior to meals and at bedtime based on the resident's blood sugar value.</p> <p>The physician's order, dated 05/15/15, indicated give Atenolol 25 mg tablet orally once daily for hypertension, hold for systolic blood pressure less than 90 and diastolic blood pressure less than 50.</p> <p>The clinical record was reviewed on 09/03/2015 at 2:25 P.M. The MAR (Medication Administration Record) revealed blood pressures were not documented on the following dates: July 2, 13, 17, 20, 25, 26, or 30, 2015 August 3, 4, 17, or 23, 2015 September 1, 2015</p> <p>The MAR further indicated blood sugar values were not documented on the following dates:</p>		<p><b>to be affected by the practice. All residents who have orders for blood pressure monitoring and blood sugar testing were identified The MAR's were reviewed to verify documentation of blood pressures being assessed and documented, as well as those residents receiving blood sugar testing prior to administration of the antihypertensive medication and insulins. All nursing staff were re-educated on proper medication administration and documentation on the Medication Administration Record in accordance with the physician orders, with emphasis on blood pressure, blood sugar testing, and insulin medications by the DHS on 9/8/15. . Nursing Inservice with PCA Pharamcy representative scheduled for 9/23/15. A minimum of 5 residents receiving antihypertensives and blood glucose monitoring will be reviewed weekly x 4 weeks, then 3 residents a week times 4 weeks, then 1 residents a week x 4 weeks, then 1 resident monthly x 3 months, to ensure ongoing compliance. . Results of these findings will be presented and reviewed in monthly QAA meetings. If any areas of concerns are identified action plans will be developed</b></p>				

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	<p>July 8, and 23, 2015 - before lunch July 10, 2015 - at bedtime August 6, 13, 18, or 27 - before lunch August 13, 16, 17, or 21, 2015 - at bedtime September 1, 2015 - before lunch</p> <p>The "Nurse's Medication Notes" on the back of the MAR did not indicate any reasons for the lack of documentation on these dates.</p> <p>During an interview on 09/04/2015 at 9:57 A.M., LPN (Licensed Practical Nurse) #2 indicated no knowledge of why there were blanks on the MAR for the blood sugar or blood pressure. LPN #2 further indicated if a resident refused a medication or treatment the nurse was to document a note on the back of the MAR page.</p> <p>During an interview on 09/04/2015 at 10:18 A.M., Unit Manager #5 indicated if a resident refused a treatment or medication it was to be documented on the back of the TAR (Treatment Administration Record)/MAR.</p> <p>During an interview on 09/04/2015 at 10:28 A.M., LPN #2 indicated if the doctor's order specified a resident's blood pressure medication was to be held for a low blood pressure, the nurse must first</p>		<b>and continued until substantial compliance is achieved</b>	

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	<p>check the blood pressure and if it was below the parameters, the medication was to be held and the blood pressure noted on the MAR. LPN #2 further indicated if the blood pressure medication was held, the nurse was to circle her initials on the MAR.</p> <p>During an interview on 09/04/2015 at 2:24 P.M., the DON (Director of Nursing) indicated the areas left blank on the MAR "looked like omissions" and it appeared the staff didn't take the resident's blood pressure. She indicated the staff signed the MAR but did not document a blood pressure. She further indicated by signing the MAR she was not sure if the staff gave the medication and if the nurse circles her initials on the MAR it meant that the medication was not given and the nurse should put a note on the back of the MAR documenting why the medication was not given. No documentation was noted on the back of the MAR for any of the medications or treatments not given.</p> <p>The current policy and procedure titled, "Specific Medication Administration Procedures", dated "2/1/0" [sic], was provided by the ED (Executive Director) on 09/04/2015 at 1:55 P.M. This policy indicated, "...Obtain and record any vital signs or other monitoring parameters</p>			

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F 0329 SS=D Bldg. 00	<p>ordered or deemed necessary prior to medication administration ...If resident refuses medication, document refusal on MAR or TAR ..."</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to adequately monitor and document a resident's blood pressure</p>	F 0329	<b><i>R esident #11's doctor was notified immediately by the licensed nurse of the lack of documentation of blood</i></b>	10/04/2015

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	<p>and blood sugar related to hypertension and diabetes medication use for 1 of 5 residents reviewed for unnecessary medications. (Resident #11)</p> <p>Findings include:</p> <p>Record review of a significant change MDS (Minimum Data Set) Assessment dated 02/17/2015, on 09/03/2015 at 11:00 A.M., indicated Resident #11 had diagnoses including, but not limited to, hypertension and diabetes.</p> <p>The Physician's admission order dated 04/15/2015, indicated Novolog insulin should be given prior to meals and at bed time, based on the resident's blood sugar value.</p> <p>The Physician's order, dated 05/15/15, indicated give Atenolol 25 mg tablet orally once daily for hypertension, hold for systolic blood pressure less than 90 and diastolic blood pressure less than 50.</p> <p>The clinical record was reviewed on 09/03/2015 at 2:25 P.M. The MAR (Medication Administration Record) revealed no blood pressures were documented on July 2, 13, 17, 20, 25, 26, or 30, 2015, or August 3, 4, 17, or 23, 2015, or September 1, 2015. The MAR further indicated blood sugar values were</p>		<p><b><i>pressures and blood sugars on the MAR, and no new orders were received. Resident # 11 was re-assessed by the nurse to include blood pressure reading and assessment of signs and or symptoms of hyper or hypo glycemia. Resident did not have any adverse affects from documentation omissions. All residents receiving antihypertensives with physician orders for parameters of administration and physician orders for blood sugar levels. had the potential to be affected by the practice. All residents who have orders for blood pressure monitoring and blood sugar testing were identified The MAR's were reviewed to verify documentation of blood pressures being assessed and documented, as well as those residents receiving blood sugar testing prior to administration of the antihypertensive medication and insulins. All nursing staff were re-educated on proper medication administration and documentation on the Medication Administration Record in accordance with the physician orders, with emphasis on blood pressure, blood sugar testing, and insulin medications by the DHS on 9/8/15. . Nursing Inservice with PCA Pharmacy representative scheduled for 9/23/15.</i></b></p>		

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	<p>not recorded on July 8, and 23, 2015, before lunch, on July 10, 2015 at bed time, August 6, 13, 18, or 27, before lunch, or August 13, 16, 17, or 21, 2015 at bed time, or September 1, 2015 before lunch. The "Nurse's Medication Notes" on the back of the MAR pages did not indicate any reasons for the lack of documentation on these dates.</p> <p>During an interview on 09/04/2015 at 9:57 A.M., LPN (Licensed Practical Nurse) #2 indicated no knowledge of why there were blanks on the MAR for the blood sugar or blood pressure. LPN #2 further indicated when a resident refused a medication or treatment the nurse was to document a note on the back of the MAR page.</p> <p>During an interview on 09/04/2015 at 10:28 A.M., LPN #2 indicated if the doctor's order specified a resident's blood pressure medication was to be held for a low blood pressure, the nurse must first check the blood pressure. If it was below the parameters, the medication was to be held and the blood pressure was to be noted on the MAR. LPN #2 further indicated if the blood pressure medication was held, the nurse would circle her initials on the MAR.</p> <p>During an interview on 09/04/2015 at</p>		<p><b><i>A minimum of 5 residents receiving antihypertensives and blood glucose monitoring will be reviewed weekly x 4 weeks, then 3 residents a week times 4 weeks, then 1 resident a week x 4 weeks, then 1 resident monthly x 3 months, to ensure ongoing compliance.</i></b></p> <p><b><i>Results of these findings will be presented and reviewed in monthly QAA meetings. If any areas of concerns are identified action plans will be developed and continued until substantial compliance is achieved</i></b></p>				

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F 0332	<p>2:24 P.M. the DON (Director of Nursing) indicated the areas left blank on the MAR "looked like omissions" and it appeared the staff didn't take the resident's blood pressure. She indicated the staff signed the MAR but did not document a blood pressure. She further indicated, if the nurse circles her initials on the MAR it meant that the medication was not given and the nurse should put a note on the back of the MAR documenting why the medication was not given. No documentation was noted on the back of the MAR for any of the medications or treatments not given.</p> <p>The current facility policy and procedure titled, "Specific Medication Administration Procedures", dated "2/1/0" [sic], was provided by the ED (Executive Director) on 09/04/2015 at 1:55 P.M. This policy indicated, "...Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration ...If resident refuses medication, document refusal on MAR or TAR ..."</p> <p>3.1-48(a)(3)</p>				
	483.25(m)(1)				

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SS=D Bldg. 00	<p><b>FREE OF MEDICATION ERROR RATES OF 5% OR MORE</b></p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% was maintained for 2 of 3 residents observed during 30 opportunities for medication error as evidenced by a medication error rate of 6.6%. (Resident #34 and #63)</p> <p>Findings include:</p> <p>1. During an observation on 09/02/2015 at 7:50 A.M., LPN (Licensed Practical Nurse) #1 administered Tamsulosin to Resident #34 before the resident was served breakfast.</p> <p>During an observation on 09/02/2015 at 9:00 A.M., Resident #34 was observed eating his breakfast of eggs, sausage and toast.</p> <p>During an interview on 09/02/2015 at 9:01 A.M., Resident #34 indicated he had not consumed any food prior to receiving his medication. Resident #34 indicated he had just received his breakfast tray around 8:50 A.M. today (09/02/2015).</p> <p>During an interview 09/02/2015 9:06</p>	F 0332	<p><b>Physician of Resident #34 and Resident #63 were notified of the occurrences with the medications on 9/2/15. by the licensed nurse. No new orders were received Residents # 34 and # 63 were reassessed by the nurse and no adverse effects were noted.</b></p> <p><b>All residents receiving flomax and Sinemet had the potential to be affected by the practice. All residents receiving flomax were reviewed and verified as receiving the medication 30 minutes after meal as prescribed. All residents receiving Sinemet were reviewed and appropriate medication times are accurately reflected on the MAR. . All licensed nursing staff were re-educated on the guideline for medication administration times. This was conducted by DHS on 9/8/15. PCA Pharmacy Inservice Scheudled for 9/23/15 for all Nurses and QMA's.</b></p> <p><b>Medication Observations will be completed on a minimum of 3 licensed staff weekly x 4 weeks, then every 2 weeks x 4</b></p>	10/04/2015			

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	<p>A.M., LPN #1 indicated she did not pay close enough attention to the order and the medication was to be given one half hour after Resident #34 consumed his meal.</p> <p>The clinical record for Resident #34 was reviewed on 09/02/2015 at 9:40 A.M. The physician orders indicated, "Tamsulosin 0.4 milligram capsule, give one capsule by mouth two times daily one half hour after meal for urinary retention". Diagnosis for the resident included, but was not limited to, urinary retention.</p> <p>2. During an observation on 09/02/2015 at 7:20 A.M., LPN #2 administered Sinemet to Resident #63 one hour and forty minutes prior to the physician's ordered time of 9:00 A.M.</p> <p>During an interview on 09/02/2015 at 9:10 A.M., LPN #2 indicated she had given Resident #63 Sinemet at 7:20 A.M., but the physician order indicated the medication was to be given at 9:00 A.M., 3:00 P.M., and 9:00 P.M.</p> <p>The clinical record for Resident #63 was reviewed on 09/02/2015 at 9:34 A.M. The physician orders indicated, "Sinemet 25/100 milligram tablet, give one tablet by mouth three times daily for</p>		<p><b>weeks, then monthly x 3 months The observations will be conducted by the DHS, ADHS, Unit Manager in conjunction with the consulting pharmacist . Result of the medication observations will be . . presented and reviewed in the monthly QAA meetings. If any areas of concerns are identified action plans will be developed and continued until substantial compliance is achieved.</b></p>	

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F 0514 SS=D Bldg. 00	<p>Parkinson's Disease at 9:00 A.M., 3:00 P.M., and 9:00 P.M." Diagnosis included, but was not limited to, Parkinson's disease.</p> <p>The current, undated policy and procedure titled, "Medication Administration Times Procedural Guidelines", was provided on 09/03/2015 at 3:25 P.M. by the DON (Director of Nursing). The policy indicated, "...Medications that have been ordered at specific time shall be administered at the time designated by the attending physician..."</p> <p>3.1-25(b)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>			

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	<p>Based on interview and record review, the facility failed to maintain accurate and complete clinical information related to assessment and treatment documentation for 3 of 17 residents reviewed for documentation. (Residents #9, #11 and #77)</p> <p>Findings include:</p> <p>1. Resident #9's clinical record was reviewed on 09/02/2015 at 9:28 A.M. The "Monthly Nursing Assessment &amp; Data Collection", dated 06/06/2015, was completed by LPN (Licensed Practical Nurse) #4. A second "Monthly Nursing Assessment &amp; Data Collection", also dated 06/06/2015, was completed by LPN #4 for Resident #9. Both assessments had different, conflicting information, charted for the resident. These differences included, but were not limited to, differences in mobility and ADL's (Activities of Daily Living), self medication knowledge, urine color and clarity, and safety.</p> <p>During an interview on 09/03/2015 1:54 P.M., LPN #4 indicated she did not know why there were two assessments done. The LPN indicated she believed that one was correct for Resident #9 and the second one was done for another resident and that she accidentally put Resident</p>	F 0514	<p><b>Resident #9's assessment was immediately corrected and the medical record contains one accurate assessment. Res #77 was discharged from the campus on 5/28/15. A modified assessment was completed to reflect an accurate MDS assessment of no open areas for resident # 77 on 9/4/15. This was conducted by the MDS support nurse. Resident #11's doctor was notified immediately by the licensed nurse of the lack of documentation of blood pressures and blood sugars on the MAR, and no new orders were received. Resident # 11 was re-assessed by the nurse to include blood pressure reading and assessment of signs and or symptoms of hyper or hypo glycemia. Resident did not have any adverse affects from omissionsdoctor was notified with no new orders. All residents whorequire completion and submission of the Minimum Data Set, receiving antihypertensives with physician orders for parameters of administration and physician orders for blood sugar levels, require completed assessments had the potential to be affected by the practice. The campus MDS Coordinator</b></p>	10/04/2015			

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	<p>#9's name on the assessment.</p> <p>During an interview on 09/03/2015 at 2:20 P.M., the Clinical Support Nurse indicated that the assessment that included the comment that Resident #9 was legally blind was the correct assessment for this resident.</p> <p>2. Resident #77's clinical record was reviewed on 09/02/2015 1:34 P.M. . The "Nursing Admission Assessment &amp; Data Collection", dated 03/25/2015, indicated the resident had an open area located on his left buttock upon admission. No further documentation was provided by the Clinical Support Nurse that indicated Resident #77 had a pressure ulcer upon admission or during his stay which began on 03/25/2015.</p> <p>During an interview on 09/03/2015, RN (Registered Nurse) #3 indicated Resident #77 did not have a pressure ulcer upon admission on 03/25/2015. She further indicated she was surprised how well the pressure ulcer he was discharged with on 03/21/2015 had healed before his return. RN #3 indicated the admission assessment for Resident #77 was incorrect.3. Resident # 11's clinical record was reviewed on 09/03/2015 at</p>		<p><b>was re educated on the RAI manual for proper coding of MDS on 9/4/15. This was completed by the MDS Support Nurse. MDS Coordinator with Clinical Support audited 672 who were triggered as having pressure ulcers to insure accurate coding of those identified residents.. In addition, all licensed staff were re-educated on accurate completion of the nursing admission assessment, with emphasis placed on the area of skin impairments. This was conducted by the DHS/Unit Manager/ADHS on 9/8/15. All residents who have orders for blood pressure monitoring and blood sugar testing were identified The MAR's were reviewed to verify documentation of blood pressures being assessed and documented, as well as those residents receiving blood sugar tesing prior to administration of the antihypertensive medication and insulins. All nursing staff were re-educated on proper medication administration and documentation on the Medication Administration Record in accordance with the physician orders, with emphasis on blood pressure, blood sugar testing, and insulin medications by the DHS on 9/8/15. . Nursing Inservice with PCA Pharamcy representative scheduled for 9/23/15.</b></p> <p><b>MDS Coordinator, DHS , ADHS</b></p>		

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	<p>11:00 A.M. The significant change MDS (Minimum Data Set) assessment, dated 02/17/2015, indicated Resident #11 had diagnoses including, but not limited to, hypertension and diabetes.</p> <p>The physician's admission order dated 04/15/2015, indicated Novolog insulin should be given prior to meals and at bedtime based on the resident's blood sugar value. The physician's order, dated 05/15/15, for Atenolol indicated give one 25 mg tablet orally once daily for hypertension, hold for systolic blood pressure less than 90 and diastolic blood pressure less than 50.</p> <p>Resident # 11's MAR (Medication Administration Record) revealed no blood pressures were documented on July 2, 13, 17, 20, 25, 26, or 30, 2015, or August 3, 4, 17, or 23, 2015, or September 1, 2015. The MAR further indicated blood sugar values were not recorded on July 8, and 23, 2015, before lunch, on July 10, 2015 at bedtime, August 6, 13, 18, or 27, before lunch, or August 13, 16, 17, or 21, 2015 at bedtime, or September 1, 2015 before lunch. The "Nurse's Medication Notes" on the back of the MAR pages did not</p>		<p><b>and nurse manager will audit 5 nursing admission assessments weekly x 4 weeks, then 3 weekly x 4 weeks, then 1 weekly x 4 weeks. MDS Coordinator, DHS, ADHS, Nurse manager will audit 3 MDS's for accurate coding weekly x 4 weeks, then 3 x 4 weeks, 2 x 4 weeks, Then 1 monthly x 3 months. The MDS support nurse will review a minimum of 2 MDS'S during routine visits to insure ongoing compliance. All residents who have orders for blood pressure monitoring and blood sugar testing were identified The MAR's were reviewed to verify documentation of blood pressures being assessed and documented, as well as those residents receiving blood sugar teting prior to administration of the antihypertensive medication and insulins. All nursing staff were re-educated on proper medication administration and documentation on the Medication Administration Record in accordance with the physician orders, with emphasis on blood pressure, blood sugar testing, and insulin medications by the DHS on 9/8/15. Results of these findings will be presented and reviewed in monthly QAA meetings. If any areas of concerns are identified action plans will be developed and continue until substantial compliance is achieved.</b></p>				

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	<p>indicate any reasons for the lack of documentation.</p> <p>During an interview on 09/04/2015 at 9:57 A.M., LPN (Licensed Practical Nurse) #2 indicated no knowledge of why there were blanks on the MAR for the blood sugar or blood pressure.</p> <p>During an interview on 09/04/2015 at 2:24 P.M. the DON (Director of Nursing) indicated the areas left blank on the MAR "looked like omissions" and it appeared the staff didn't take the resident's blood pressure. She indicated, if the nurse circles her initials on the MAR, it meant that the medication was not given and the nurse should put a note on the back of the MAR documenting why the medication was not given. No documentation was noted on the back of the MAR for any medications or treatments not given.</p> <p>The current policy and procedure titled, "Specific Medication Administration Procedures", dated "2/1/0" [sic], was provided by the ED (Executive Director) on 09/04/2015 at 1:55 P.M. This policy indicated "...Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration ...If resident</p>			

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R 0000  Bldg. 00	<p>refuses medication, document refusal on MAR or TAR ..."</p> <p>The current, undated facility policy titled, "Clinical Documentation Systems Admission Nursing Assessment and Data Collection", was provided by the ED (Executive Director) on 09/04/2015 at 1:55 P.M. and reviewed at that time. The policy indicated, "...complete and document a comprehensive assessment of the resident's current medical status..."</p> <p>The policy further indicated, "...The form shall be completed with the type of assessment, date and time of completion...Staff completing the form shall record the resident name, medical record number and attending physician on each page..."</p> <p>3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(f)(2)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 34 Sample: 8</p> <p>This State finding is cited in accordance</p>	R 0000		

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R 0295  Bldg. 00	<p>with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure medications, kept in resident rooms for self-administration, were stored appropriately in locked compartments for 2 of 2 residents reviewed for self-administration of medications. (Resident #4 and #8)</p> <p>Findings include:</p> <p>During an observation on 09/04/2015 at 11:48 A.M., Resident #4 had the following medications in an unlocked cabinet above the sink: Plavix 75 mg (milligrams), fish oil 1200 mg, Lasix 20 mg, Restasis 0.05%, Simbrinza 1% / 0.2%, acetaminophen 325 mg, Dulcolax 10 mg suppository, Milk of Magnesia, and Refresh eye drops. The resident indicated she does not lock up her medications.</p> <p>During an observation on 09/04/2015 at 11:55 A.M., Resident #8 had the</p>			R 0295	<p><b>Resident # 4 and Resident #8 were re educated along with their family members regarding the policy for maintaining and securing medications. and Locked boxes were placed in resident # 4 and resident # 8' room. and medications were locked and secured for proper medication storage on 9/5/15.</b></p> <p><b>Residents who self administer had the potential to be affected.</b> <b>All nursing staff were inserviced on 9/8/15 regarding proper medication storage, utilizing the guidelines for self administration policy . This was conducted by the DHS . Residents on assisted living were audited and interviewed to insure that no other residents had medications that were not secured. PCA Pharmacy will be holding an in-service on 9/23/15</b> <b>A minimum of 3 residents will be randomly</b></p>		10/04/2015

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	<p>following medications in an unlocked cabinet above the sink: Advair Diskus 250/50, Aleve, Docusate, levothyroxine 50 mcg (micrograms), losartan potassium 50 mg, omeprazole 20 mg, sertraline 25 mg, simvastatin 40 mg, acetaminophen 325 mg, albuterol, Milk of Magnesia, and mucus relief. The resident indicated she does not lock up her medications.</p> <p>During an interview on 09/04/2015 at 2:20 P.M., LPN (Licensed Practical Nurse) #1 indicated the medications residents keep in their room are kept in a high cabinet. Residents may lock their doors but typically do not unless they are leaving the building. Only two residents self administer their medications at this time. They are reassessed every three months.</p> <p>During an interview on 09/04/2015 at 3:45 P.M., the DON (Director of Nursing) indicated medications kept in resident rooms for self-administration should be locked in the provided drawer, in a lockbox in the resident's room, or the door to the resident's room should remain locked.</p> <p>The current facility policy titled, "Guidelines for Self Administration [sic] of Medications", dated August 2011, was provided by the Administrator on</p>		<p><b>audited/interviewed to insure ongoing compliance. this will be conducted weekly x 4 weeks, then every 2 weeks x 4 weeks, then monthly x 3 months this will be conducted by DHS, ADHS or unit manager. . . Results of these findings will be presented and reviewed in the monthly QAA meetings. If any areas of concerns are identified action plans will be developed and continued until substantial compliance is achieved.</b></p>	

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	09/04/2015 at 1:55 P.M. and reviewed at that time. The policy indicated, "...The medication will be kept in a locked drawer in the residents' room ..."				