STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	(X3) DATE SURVEY COMPLETED
	155198	A. BUILDING 00	06/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARQUETTE	8140 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00195674. Complaint IN00195674-Substantiated. No deficiencies related to the allegations are cited. Survey dates: June 6, 7, 8, 9, 10, 13, &14, 2016 Facility number: 000105 Provider number: 155198 AIM: N/A Census bed type: SNF: 65 Residential: 56 Total: 121 Census payor type: Medicare: 16 Other: 49 Total: 65 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Quality Review was completed by 21662 on June 16, 2016.			
F 0224 SS=E Bldg. 00	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review the facility failed to prevent diversion of controlled medications for 4 of 4 residents reviewed for abuse. (Residents 6, 12, 39 and 43). Findings Include: A document titled, "INVESTIGATION" dated 5/23/2016, provided by the Director of Nursing (DON) indicated on 5/23/2016, the DON received a phone call from a female who had information regarding an employee (a nurse) at the facility who was potentially stealing medications. She indicated the nurse worked for another local facility where she and the nurse became friendly and she had allowed the nurse to work for her in her home when she discharged from that facility. The female indicated the	F 0224	It is the practice of Marquette to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of property. The facility does not use verbal, sexual, physical, mental abuse, corporal punishment or involuntary seclusion. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #6: Resident has had no adverse effects from the alleged deficient practice. The resident continues to have pain assessments completed every shift with interdisciplinary team weekly reviews. MD reviews conducted upon request with adequate adjustments to pain regimen. The facility has provided financial reimbursement for any diverted medications. Resident #12:	06/29/2016

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	nurse had stolen her personal supply of hydrocodone (a pain medication) and replaced it with Tylenol, and had also stolen Ambien (a medication for sleep) and flexeril (a muscle relaxant). She indicated she filed a police report regarding the stolen medications in November of 2015, and the police were unable to do anything due to lack of proof the theft occurred. The DON indicated she immediately informed the Administrator (ADM) and the Human Resources (HR) Coordinator. An investigation was initiated on 5/23/2016, by the facility. The HR Coordinator and the DON reviewed the employment applications for all nurses that had worked at the previous facility, and it was determined that two nurses worked at the former facility and the nurses narcotic administration records were reviewed for trends, abnormalities and inconsistencies. No abnormalities were noted for one of the nurses. The other nurse had frequent narcotic (pain medication) prn (as needed) use with four residents on shifts that she worked. The nurse was removed from the schedule for probable cause of drug diversion.. An interview with the nurse was conducted by Administrator, DON and Assistant Director of Nursing) ADON. Records reviewed with staff the member.		Resident has had no adverse effects from the alleged deficient practice. The resident continues to have pain assessments completed every shift with interdisciplinary team reviews weekly. MD reviews conducted upon request with adequate adjustments to pain regimen. The facility has provided financial reimbursement for any diverted medications. Resident #39: Resident has been successfully discharged to home. Resident #43: Resident has been successfully discharged to home. The following screening items were completed prior to hire: · Professional License Search completed prior to hire showing license as active, no previous action. · Physical Assessment was completed prior to hire with no concerns. · Drug Screen was completed prior to hire, with negative results. · Criminal Background Check was completed prior to hire with no findings. · OIG Check was completed prior to hire with no findings. · Reference checks (3) were completed prior to hire with positive findings. Review of community policies was completed upon hire on 9/8/2015 with nurse's signature confirming understanding. Resident rights and abuse policy was reviewed upon hire on 9/8/2015, with nurse successfully passing the post-test. Prevention policy was	

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	Detailed record reviews were conducted on the identified four residents by the facility. The DON, ADON, and the ADM indicated the facility conducted an interview with the nurse in question to which she admitted to "drug diversion" for the four residents reviewed. The nurse indicated she had an addiction to medication related to chronic back pain due to degenerative disk disease and had back surgery a couple of years ago and had poor pain control since that time. (The nurse verbalized a sense of relief that the truth had come out that she was taking residents medications and indicated she felt she needed help). The nurse indicated she did not let her impairment affect the well being of any resident. The nurse indicated she knew what she did was wrong and was relieved she had admitted the addiction problem. The nurse provided a statement to the facility: "I admit to have diverted the drugs. I suffer from chronic pain from degenerative disk disease and lupus. It was wrong to do. I am admitting I have an addiction problem and need help. I want to go to rehab and/or whatever is necessary to get help." The nurse agreed to go for a drug screen and was accompanied by the ADON to a clinic for testing. The nurse was notified on		in place with noted adherence. This anonymous concern was identified as having the potential to affect facility residents; therefore a thorough investigation was immediately initiated. The staff member in question was removed from the schedule pending results of the investigation. Investigation findings were found to occur during an isolated time frame with an isolated employee with corrective actions immediately implemented. Facility provided financial reimbursements to individuals affected. Surveyors complemented the Director of Nursing on the completeness and thoroughness of the investigation. Facility notified appropriate agencies of findings including the Indianapolis Metropolitan Police Department, The Attorney General's Office and The Indiana State Department of Health. **How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**All residents have the potential to be affected by the alleged deficient practice. All residents' narcotic administration records were reviewed for trends, abnormalities, and inconsistencies with no additional findings. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	5/26/16 (the day of her statement), that she would be suspended until Administration conferred with the HR Coordinator to review all findings. Actions taken by the facility: Narcotic records were reviewed for any noted trends, abnormalities and inconsistencies. The nurse was contacted for a second interview to confirm the affected residents, and obtain additional information regarding the amount of medications diverted. The nurse confirmed that only four residents were affected by the misappropriation. The nurse confirmed the medications diverted from the residents were, hydrocodone/APAP, ativan (an anti-anxiety medication), and Tramadol (a pain medication). The nurse was unable to recall the exact numbers for the medications that were taken. The nurse indicated that all four residents received 80-90% of the PRN's (as needed) documented. The nurse admitted to poor documentation practices as evidenced by late entries. The nurse indicated she did not always document in the electronic medical record when medications were administered but would wait until she sat down and completed her shift documentation all at one time. The nurse indicated the poor documentation practice was a factor in multiple of the		**practice does not recur?**The facility has reviewed the Abuse Prevention Policy and found it to be complete. Nursing personnel have been re-educated on the policy with emphasis on misappropriation of belongings. Nurses and QMA's have been re-educated on the medication administration policy as it relates to drug diversions. **How the corrective action will be monitored to ensure the deficient practice will not recur?**A misappropriation of resident medications audit will be conducted by the DON or designee weekly for 4 weeks, then bi-weekly for 2 months and then monthly thereafter. The results of the audits will be reviewed by the Quality Assurance Team. **Compliance Date:** June 29, 2016	

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	documentation discrepancies such as missing entries and administration times not always matching times that medications were pulled from the narcotic box. The nurse reported that taking the resident medications at Marquette was a recent development that began late February-early March. The four residents who were affected by the misappropriation had a thorough medication audit completed by the facility from February 2016-May 2016. Resident #6: Norco: 30 tablets x 80-90%=Resident received 24-27 tablets. Resident #12: Norco: 54 tablets x 80-90%=The resident received 43-48 tablets. Tramadol: 8 tablets x 80-90% =The resident received 5-7 tablets. Resident #39: Tramadol: 16 tablets x 80-90%=The resident received 12-14 tablets and Ativan: 11 tablets x 80-90% = The resident received 9-10 tablets. Resident #43: Norco: 19 tablets x 80-90%=The resident received 15-17 tablets. a. On 6/10/16 at 11:00 a.m., a record review of Resident #6 was completed. Diagnoses included, but were not limited to, hypertension, major depressive disorder and unspecified pain.			

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	The physicians orders dated May 2016, included, but were not limited to, the following order: Norco (a narcotic pain medication) 5-325 mg (milligrams) one tab every six hours as needed for pain. b. On 6/10/16 at 11:05 a.m., a record review of Resident #12 was completed. Diagnoses included, but were not limited to, muscle weakness, physical debility and orthopedic aftercare. The physicians orders dated May 2016, included, but were not limited to, the following orders: Norco 5-325 mg one tab every six hours as needed. Tramadol (a pain medication) 50 mg one tablet two times daily. c. On 6/10/16 at 11:10 a.m., a record review of Resident #39 was completed. Diagnoses included, but were not limited to, unspecified pain. The physicians orders dated May 2016, included, but were not limited to, the following orders: Lorazepam (an antianxiety medication) 0.25 mg one tab every six hours as needed for anxiety. Tramadol 50 mg one to two tabs as needed for pain every six hours. d. On 6/10/16 at 11:15 a.m., a record			

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	review of Resident #43 was completed. Diagnoses included, but were not limited to, polymyalgia rheumatica (an inflammatory disorder causing muscle pain and stiffness around the shoulders and hips) and heart failure. The physicians orders dated May 2016, included but were not limited to, the following order: Norco 5/325 mg one tablet every four hours as needed for pain. On 06/13/2016 at 11:00 a.m., during interview with the DON, she indicated a referral was made to the Nursing Licensing Board regarding the drug diversion for the nurse involved. She indicated the resident's family was contacted regarding the missing medications by the Assistant ADM, and the family opted for the medications to be replaced at no cost to the resident. Additionally, she indicated the resident was closely monitored for pain after every administration of pain medication and was documented as effective. She additionally indicated the resident had a pain assessment weekly. The resident's pain was addressed weekly in morning meetings with ADM and nursing staff where close monitoring of pain control was discussed.			

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	3.1-28(a)			
F 0329 SS=D Bldg. 00	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. 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. Based on interview and record review, the facility failed to monitor specific targeted behaviors for the use of antidepressants and hypnotics medications and to monitor for the side effects of a hypnotic medication for 2 of 5 resident reviewed for unnecessary medications (Resident's #190 and #186).	F 0329	It is the practice of Marquette to ensure that each resident's drug regimen is free from unnecessary drugs. **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #190: No concerns identified with Resident's medication list, no unnecessary medications identified upon medical record	06/29/2016

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	Findings include: 1. During record review on 6/9/16 at 12:21 p.m., Resident #190 diagnoses included, but were not limited to, sepsis, urinary tract infection, anemia, heart failure, insomnia, unspecified mood affective disorder, and major depressive disorder. The Physician orders, dated 6/16, indicated Resident #190's medications included, but were not limited to, Lexapro (an antidepressant) 10 mg (milligrams) every morning for depression, Trazadone (an antidepressant) 50 mg at bedtime for mood affective disorder and insomnia and Ambien (a hypnotic) 5 mg for insomnia. No behavioral monitoring sheets for depression or insomnia were found in the unit behavioral monitoring book. Resident #190's medication administration record (MAR) or treatment administration record (TAR) did not indicate to monitor for side effects of his medications. During an interview, on 6/10/16 at 3:45 p.m., LPN #6 indicated there was no monitoring for side effects of his		review. Resident's original admission date was 5/25/16. Resident was hospitalized from 5/28/2016 – 6/2/2016. Resident was re-admitted to community on 6/2/2016. Assessment period (ARD): 6/2/2016 -6/9/2016, with MDS completion date of 6/10/2016. Per RAI guidelines, the care plan completion date was scheduled for completion by 6/17/2016. Interim care plans were developed upon admission on 5/25/16 and re-admission for psychotropic drug use and psychosocial well-being with interventions to observe for side effects of medication and remained in place until master care plan completion date. Abnormal involuntary movement assessments were completed on 5/25/2016 and 6/3/2016 showing no adverse side effects. Admission diagnosis showed history of major depressive disorder, mood disorder, and insomnia. Admission orders: Trazadone, Ambien, and Lexapro. Resident did not have any orders for anti-psychotic medications. MDS assessments reviewed. Comprehensive 5-day assessment completed on 6/10/2016, showing mood and behavior assessments were completed. MDS identified sleep disturbances and depression as triggers. MDS identified resident was prescribed anti-depressant and hypnotics. Resident #186: No concerns identified with	

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	medications and no monitoring for signs of depression or insomnia in place for Resident #190 2. On 06/08/2016 at 2:56 p.m., resident # 186's record was reviewed. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side, major depressive disorder and pain. Physician orders for June 2016 included the medication profile for the resident which included, but were not limited to, venlafaxine hcl (antidepressant) 150 mg daily. Care plans included, but were not limited to: 1. " I am receiving antidepressant drug on a regular basis... Intervention: Conduct 1-on 1 visit with Resident to discuss current status and adjustment to lifestyle changes. Monitor for side effects of medication (constipation, dry mouth, anxiety, agitation, headache, falls) report promptly to physician." 2. " I am at risk for falling due to impaired balance following cva with rt [related to] sided weakness, history of falling and use of an antidepressant... Intervention: Assist [name of resident] to wear non-stick footwear that fits. assist with transfers as needed. Instruct [name of resident] on		Resident's medication list, no unnecessary medications identified upon medical record review. Admission Date: 5/27/2016. ARD Assessment Dates: 5/30/16-6/3/16. Completion Date 6/8/16. Per RAI guidelines, the care plan completion date was scheduled for completion by 6/15/2016. MDS assessment reviewed showing mood and behavior assessments were completed. MDS identified depression as a trigger. Interim Care Plan developed on 5/28/2016 for psychotropic drug use and psychosocial well-being with interventions for side effect monitoring and remained in place until completion of master care plan. Admission Diagnosis included Major Depressive Disorder. Admission Orders: Venlafaxine ER 150mg daily. Review of Resident history shows Resident has been receiving psychiatrist treatment for Major Depressive Disorder since 2013. Resident had prior admission to facility in 2014, resident was being treated for ongoing management of Major Depressive Disorder with Wellbutrin and Remeron. The facility arranged consult with Clinical Psychologist during the 2014 admission. **How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?**	

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	safety measures to reduce the risk of falls (posture, changing positions, use of handrails), keep areas free of obstructions to reduce the risk of falls or injury. Keep nurse call light within easy reach. Instruct [name of resident] to use call bell or call out for assistance. Therapy as ordered." A progress note dated 5/30/16 at 12:15 p.m., indicated, the resident's mood was "pretty decent considering the circumstances." A book titled "Behavior book 1 A" under tab "C" lacked behavior monitoring sheets for the resident regarding Antidepressant use. No behavior monitoring for the antidepressant was found in the electronic documentation system by nurse RN #4. During an interview on 06/09/2016 at 2:20 p.m., RN #4 indicated there was no specific behavior monitoring for antidepressant use for the resident and were unable to locate specific behavior monitoring documentation in the computer or in the behavior book for the resident. She directed the question of behavior monitoring to the Social Services Director (SSD). During an interview on 06/09/2016 at		All residents receiving anti-depressant and/or hypnotic medications have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Behavior management policy was reviewed. Staff education has been provided on the behavior management policy. **How the corrective action will be monitored to ensure the deficient practice will not recur?** A behavior management audit relative to antidepressant and hypnotic medications will be conducted by the DON or designee weekly for 4 weeks, then bi-weekly for 2 months and then monthly thereafter. The results of the audits will be reviewed by the Quality Assurance Team. **Compliance Date:** June 29, 2016	

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	2:27 p.m., the SSD indicated the facility currently had no behavior monitoring for the resident for his antidepressant use. She indicated she had a care plan, but no a behavior plan or behavior monitoring. 3.1-48(a)(3)			
F 0371 SS=F Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure food items, pans and plastic containers were stored under sanitary conditions. This deficient practice had the potential to affect 65 of 65 residents served food from the main kitchen. Findings include: During a kitchen tour on 6/6/16 at 10:31 a.m., with the Director of Food and Beverage and the Executive Chef in	F 0371	It is the practice of Marquette to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, and prepare, distribute, and serve food under sanitary conditions. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The wet pans and containers found during the survey were immediately removed and properly cleaned and dried. The dented cans were	06/29/2016

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	attendance the following observations were made: 1. A clear liquid was beaded on top and in between metal pans and plastic food containers sitting on a large metal cart. When the top pans and plastic containers were lifted the clear liquid ran down onto the next pan or container. 3--large rectangular pans 3--small square pans 3--square plastic food containers 4--rectangular food containers During an interview at that time, the Executive Chef indicated the clear liquid was water and the pans and plastic containers should be dry before staff put them away onto the metal shelves. 2. In the dry storage area there were dented cans observed sitting on the shelves. 1--6 lb (pound) 8 oz (ounce) can of Peach halves 1--111 oz can of Black beans 1--6 lb 15 oz can of White hominy 1--46 oz can Grapefruit segments 1--5 lb 8.25 oz can Artichoke hearts During an interview at that time, the Executive Chef indicated the dented cans should not have been on the shelves. A current document titled "Procedure"		removed and discarded during the survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected. This is being addressed by the systems described below. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** As indicated in the survey report the community has a policy in place regarding kitchen sanitation. The policy has been reviewed and found to be complete. Food service personnel have been re-educated on this policy. Additional systemic changes are being monitored through our QA program as indicated below. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Food and Beverage Director or designee is conducting quality improvement audits of kitchen sanitation. In addition to the routine sanitation audits conducted daily, audits of proper drying methods and dented cans are being completed three times weekly for four weeks; weekly for four weeks; then monthly thereafter. The	

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	155198		06/14/2016

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	undated, provided by the Director of Food and Beverage on 6/13/16 at 11:24 a.m., indicated "...9. Remove pots and pans and plan open side down to air dry. 10. Stack dry pans in appropriate place...." A current untitled and undated document, provided by the Director of Food and Beverage on 6/13/16 at 11:24 a.m., indicated "Policy: Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance...STORAGE OF DAMAGED CONTAINERS: DO NOT USE:.. 4. Any can that is dented, rusted, leaking or bulging." 3.1-21(i)(3)		results of all audits will be reviewed by the Quality Assurance Team monthly for additional recommendations as necessary. **Compliance Date:** June 29, 2016	
F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug			

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	records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation, interview, and record review the facility failed to date medication when opened and failed to discard expired medication in 2 of 5 medication carts and 2 of 3 medication storage rooms reviewed for medication storage (Resident #3, #19, #132, #38 and #155). Findings include:	F 0431	It is the practice of Marquette to label drugs in accordance with currently accepted professional principles and include appropriate accessory and cautionary instructions and expiration date when applicable; and in accordance with state and federal laws the facility does store all drugs and biologicals in locked compartments under proper temperatures and permits only authorized personnel to have access to keys. **What**	06/29/2016

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	1. During medication storage review on 6/13/16 at 9:00 a.m., the Township medication cart had the following: a. 3 vials containing 0.5 mg/2 ml (milligrams/milliliter) of Budesonide (An Inhalation Suspension) for Resident #3 in an open foil package, not dated when opened. b. 14 vials containing 0.5 mg/3 ml of Ipratropium Albuterol (an inhalation suspension) for Resident #3 in a box without the foil package and not dated when opened. c. a bottle of Systane 0.3-0.4% eye drops for Resident #3 with an open date of 9/23/15. d. a bottle of Latanoprost 0.005% eye drops for Resident #19 opened 3/26/16 and labeled to discard after 5/10/16. e. 3 vials of 0.5 mg/3 ml of Ipratropium Albuterol was found laying in the bottom of the cart. The medication storage room in the Township unit, had a vial of 2 mg/ml Lorazepam for Resident #132 in the refrigerator lock box that expired 5/16. During an interview with LPN #2 on 6/13/16 at 9:30 a.m., she indicated eye drops should be kept for 30 days unless instructed otherwise from the pharmacy, medications should be dated when		**corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #3: Resident displayed no negative outcome from the alleged deficient practice. The medication Budesonide was tracked by using the RX number. The medication was delivered to the facility on 6/8/2016 at 5:51am. Manufacturer instructions were reviewed for storage recommendations – medication is good for 2 weeks after the foil envelope has been opened. The first dose of the new supply was administered on 6/8/2016 at 6:47am. No expired medications were administered. The medication Ipratropium Albuterol was tracked by RX number. The medication was delivered to the facility on 6/7/2016 at 5:52am. Manufacturer instructions were reviewed for storage recommendations – medication should be protected from light before use, therefore, keep unused vials in the foil pouch or carton. Do not use after the expiration date printed on the carton. The expiration date on the carton was September 2017. The first dose of the new supply was administered on 6/8/2016 at 11:27am. No expired medications were administered. The medication Systane was tracked by RX number. The medication was delivered to the facility on	

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	opened, and expired medications should be destroyed. 2. During medication review on 6/13/16 at 9:45 a.m., the Heritage medication cart was found to have 4 vials containing 0.5 mg/2 ml of Budesonide for Resident #38 in an open foil package, not dated when opened. a. The medication storage room in the Heritage unit, had a vial of 2 mg/ml Lorazepam for Resident #155 in the refrigerator lock box that expired 6/1/16. 3. During medication review on 6/13/16 at 1:15 p.m., the Pathways medication storage room was found to have a vial of Tuberculin solution opened and not dated. The Facility policy, titled "Storage and Expiration of Medications, Biological's, Syringes and Needles" dated 01/01/13, received from the Director of Nursing on 6/13/16 at 3:45 p.m., and deemed as the current policy indicated "... 4. Facility should ensure that medications and biological's: 4.1 Have an Expiration Date on the label; 4.2 Have not been retained longer than recommended by manufactures or supplier guidelines...5. Once any medication or biological package is opened, Facility should follow		6/10/16 at 4:13am. The manufacturer recommendations were reviewed for storage recommendations – medication's expiration date is listed on the bottle. Resident #19: Resident displayed no negative outcome from the alleged deficient practice. Resident #132: Resident displayed no negative outcome from the alleged deficient practice. Resident has an order for Lorazepam as needed. A review of last 3 months of medication administration was completed. Resident has not received PRN Lorazepam at any time during the review period. Resident did not receive an expired medication. Resident #38: Resident displayed no negative outcome from the alleged deficient practice. The medication Budesonide was tracked by using the RX number. The medication was delivered to the facility on 5/17/2016 at 7:24am. Manufacturer instructions were reviewed for storage recommendations – medication is good for 2 weeks after the foil envelope has been opened. The medication was discarded since the date opened was undetermined. Resident #155: Resident displayed no negative outcome from the alleged deficient practice. Resident has an order for Lorazepam as needed. Resident's medication administration list was reviewed.	

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	manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date was opened...16. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biological's...." 3.1-25(o)		Resident has not received any doses of the Lorazepam after the expiration date. The vial of Tuberculin solution was tracked by RX number. The vial was received by the facility on 6/1/2016 at 7:22am, indicating that the vial had not expired prior to 6/13/2016. The vial was discarded since the date did not identify the actual date opened. **How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. Medication storage audits have been completed to ensure compliance with medication storage and proper medication labeling. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Staff education has been provided on the medication storage policy. Medication storage areas have been checked for policy compliance. Nursing managers will provide oversight to ensure medication storage policy is upheld. **How the corrective action will be monitored to ensure the deficient practice will not recur?** A medication storage audit will be conducted by the DON or designee weekly for 4 weeks, then bi-weekly for 2	

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			months and then monthly thereafter. The results of the audits will be reviewed by the Quality Assurance Team. **Compliance Date:** June 29, 2016	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Residential Census: 56 Residential sample: 7 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.	R 0000		
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on observation, interview and record review, the facility failed to ensure the correct medication was administered to 1 of 5 residents observed for medication administration (Resident #8) Finding includes:	R 0247	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Resident #8 has had no adverse effects from the alleged deficient practice. On the date that the alleged deficient practice was observed, the incorrect medication was	06/29/2016

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	On 6/14/16 at 8:05 a.m., QMA (Qualified Medication Aide) #1 was observed placing medications in a white papercup for Resident #8. One of the medications QMA #1 placed in the white papercup and was observed administering to the resident was Amlodipine/Benazepril (blood pressure medication) 5-10 mg (milligrams). The label on this medication indicated Amlodipine/Benazepril 5-10 mg take one capsule by mouth every morning. Resident #8's medications were reconciled on 6/14/16 at 2:20 p.m. with the Physician orders, dated June 2016. The Physician orders, dated June 2016, included, but were not limited to, the following orders: 5/7/16--Amlodipine Besylate 5 mg give one tablet by mouth once a day for essential primary hypertension (high blood pressure). LPN #3 was made aware of the descripency between the ordered medication and the medication, which had been given on this date at 8:05 a.m. She indicated at that time, she would check into the situation. During an interview on 6/14/16 at 2:30 p.m., LPN #3 indicated the Amlodipine Besylate and the Amlodipine/Benazepril were both on the medication cart and the incorrect medication was given. She		removed. Resident's physician and family were notified and a medication error report was completed. **How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. An audit of all resident medication orders, Medication Administration Records, and available medications was completed by the Director of Assisted Living and no further errors were found. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The community has reviewed the Medication Administration Policy and found it to be complete. Community nursing personnel have been re-educated on the policy with emphasis on the process for administering patient medication. An audit of all residents' medication orders and Medication Administration Records was conducted with no further errors found. **How the corrective action will be monitored to ensure the deficient practice will not recur?** An audit of medication orders and Medication Administration Records will be conducted by the Director of Assisted Living or designee.	

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	indicated the Amlodipine Besylate should have been given as ordered on the Medication Administration Record and Physician orders. She indicated it was her understanding since the resident was readmitted on 5/7/16, she had been getting the Amlodipine/Benazepril instead of the Amlodipine Besylate. At that time she had the Amlodipine Besylate medication card with a fill date of 4/30/16, there were 30 pills filled on that date. As of 6/14/16, there were only 12 pills given off that medication card. A current policy titled "General Dose Preparation and Medication Administration" dated 12/1/07, provided by the Director of the Assisted Living on 6/14/16 at 3:40 p.m., indicated "...Procedure:..3.7 Facility staff should verify that the medication name and dose are correct...4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident, as set forth in Appendix 17: Facility Medication Administration Times Schedule. 4.1.2 Confirm that the MAR [Medication Administration Record] reflects the most recent medication order...."		Audits will be designed to ensure that medications are being administered according to facility's policy and in compliance with the regulations. The frequency of these audits will occur as follows: · Medication cart will be monitored weekly for 1 month · Medication cart will be monitored bi-weekly for 2 months · Medication cart will be monitored monthly for 3 months **Compliance Date:** June 29, 2016	

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R 0273 Bldg. 00	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, interview and record review, the facility failed to ensure food items, pans and plastic containers were stored under sanitary conditions for 56 of 56 residents served food from the main kitchen. Findings include: During a kitchen tour on 6/6/16 at 10:31 a.m., with the Director of Food and Beverage and the Executive Chef in attendance the following observations were made: 1. A clear liquid was beaded on top and in between metal pans and plastic food containers sitting on a large metal cart. When the top pans and plastic containers were lifted the clear liquid ran down onto the next pan or container. 3--large rectangular pans 3--small square pans 3--square plastic food containers 4--rectangular food containers During an interview at that time, the	R 0273	It is the practice of Marquette to procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and store, and prepare, distribute, and serve food under sanitary conditions. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The wet pans and containers found during the survey were immediately removed and properly cleaned and dried. The dented cans were removed and discarded during the survey. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected. This is being addressed by the systems described below. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** As	06/29/2016

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	Executive Chef indicated the clear liquid was water and the pans and plastic containers should be dry before staff put them away onto the metal shelves. 2. In the dry storage area there were dented cans observed sitting on the shelves. 1--6 lb (pound) 8 oz (ounce) can of Peach halves 1--111 oz can of Black beans 1--6 lb 15 oz can of White hominy 1--46 oz can Grapefruit segments 1--5 lb 8.25 oz can Artichoke hearts During an interview at that time, the Executive Chef indicated the dented cans should not have been on the shelves. A current document titled "Procedure" undated, provided by the Director of Food and Beverage on 6/13/16 at 11:24 a.m., indicated "...9. Remove pots and pans and plan open side down to air dry. 10. Stack dry pans in appropriate place...." A current untitled and undated document, provided by the Director of Food and Beverage on 6/13/16 at 11:24 a.m., indicated "Policy: Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value and appearance...STORAGE OF		indicated in the survey report the community has a policy in place regarding kitchen sanitation. The policy has been reviewed and found to be complete. Food service personnel have been re-educated on this policy. Additional systemic changes are being monitored through our QA program as indicated below. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place?** The Food and Beverage Director or designee is conducting quality improvement audits of kitchen sanitation. In addition to the routine sanitation audits conducted daily, audits of proper drying methods and dented cans are being completed three times weekly for four weeks; weekly for four weeks; then monthly thereafter. The results of all audits will be reviewed by the Quality Assurance Team monthly for additional recommendations as necessary. **Compliance Date:** June 29, 2016	

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	DAMAGED CONTAINERS: DO NOT USE:.. 4. Any can that is dented, rusted, leaking or bulging."			