

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155400	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/14/2014
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NAME OF PROVIDER OR SUPPLIER LIBERTY VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 4600 E JACKSON ST MUNCIE, IN 47303
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F000000	<p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 1/27/14. This visit included the PSR to the Investigation of Complaint IN00141860.</p> <p>Complaint IN00141860 - Corrected</p> <p>Survey dates: March 13 and 14, 2014</p> <p>Facility number: 000269 Provider number: 155400 AIM number: 100267720</p> <p>Survey Team: Betty Retherford RN, TC Shelley Reed RN</p> <p>Census bed type: SNF: 6 SNF/NF: 68 Total: 74</p> <p>Census payor type: Medicare: 6 Medicaid: 55 Other: 13 Total: 74</p> <p>These deficiencies reflect state</p>	F000000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report.</p> <p>Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies.</p> <p>The Plan of Correction is prepared and submitted because of requirements under State and Federal law.</p> <p>Please accept this Plan of Correction as our credible allegation of compliance.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000332 SS=D	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed by Debora Barth, RN.</p> <p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure the facility was free of a medication error rate greater than 5 percent for 2 of 34 medications observed affecting 2 of 13 residents resulting in a medication rate of 5.8% affecting 2 of 13 residents observed during medication pass. (Resident # 9 and #14) Findings include: 1. During a medication administration observation on 3/13/14 at 3:45 p.m., Resident #9 was given 1 tablet Ferrex (iron) 150 mg, 1 tablet Os-cal with vitamin D 500 mg and artificial tear drops, 1 drop in each eye. LPN #1 exited Resident #9's room and indicated she was finished. During medication reconciliation on</p>	F000332	<p>1. Resident #9 and #14 have been observed and are receiving their medications per physician's orders 2. All other residents have the potential to be affected The residents have been observed and are receiving their medications per physician's orders 3. The facility's policy for Medication Administration has been reviewed and no changes are indicated at this time (See Attachment A) The nurses and QMAs will be re-educated on Medication Administration with a special focus on following physician's orders. This directed in-service will be provided by Hoosier Owners and Providers for the Elderly on April 2, 2014 which will be submitted to ISDH by April 15, 2014 All nurses and QMAs have been observed during medication pass to ensure medications are given per physician's orders and a Medication Pass Procedure form has been completed (See Attachment B). A Physician</p>	04/03/2014

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	<p>3/13/14 at 4:10 p.m., the physician order's indicated Reglan (medication used to treat heartburn) 5 mg should have been given with the 4:00 p.m. medication pass. The Director of Nursing (DoN) was asked to verify the Medication Administration Record and omission of the medication.</p> <p>During an interview on 3/14/14 at 10:10 a.m., the Assistant Director of Nursing (ADoN) indicated LPN #1 verbalized she omitted Reglan. The ADoN indicated Resident #9 also informed LPN #1 the Reglan was omitted.</p> <p>During an interview on 3/14/14 at 11:00 a.m., Health Facility Administrator and Corporate Nurse questioned why the Reglan was considered an error since the medication was given within the 1 hour time frame. They were informed the medication was an error because the nurse forgot to give the medication, admitted she forgot the medication and moved on to another resident.</p> <p>At 11:30 a.m., the HFA and DoN brought Resident #9 in the conference room. The resident indicated she did not ask for the</p>		<p>Orders Monitoring log (See Attachment C) and a Medication Administration Monitoring form (See Attachment D) has been implemented. 4.</p> <p>The DON/designee will be responsible for observing medication pass for 3 nurses/QMAs on alternating shifts to ensure medications are being passed per physician's orders on scheduled work days as follows: Daily for 2 weeks, weekly for 2 weeks, monthly for 2 months, then quarterly thereafter. Should concerns be found, immediate corrective action will occur. Results of these reviews will be discussed during the facility's quarterly QA meetings and the plan adjusted if indicated.</p>		

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	<p>Reglan. She indicated the medication was in applesauce and she could not verify which medication she received.</p> <p>The clinical record review was completed on 3/14/14 at 10:30 a.m. The Minimum Data Set (MDS) assessment, dated 12/29/13, indicated Resident #9 was cognitively intact. Diagnoses included, but were not limited to, rheumatoid arthritis, congestive heart failure, chronic airway obstruction and gastroesophageal reflux disease.</p> <p>The most recent health care plan problem indicated Resident #9 was at risk for indigestion, nausea, vomiting, reflux and aspiration. One of the approaches to the problem indicated "mechanical soft diet, administer medications per order and monitor for signs and symptoms of gastric pain".</p> <p>Review of the current facility policy, dated 8/10, titled "MEDICATION ADMINISTRATION POLICY AND PROCEDURE", provided by the Director of Nursing on 3/14/14 at 10:53 a.m., included, but was not limited to, the following:</p>						

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	<p>"PURPOSE: To administer medications according to the guidelines set forth by the State and Federal regulations.</p> <p>PROCEDURE:</p> <p>1. Medication will be administered within 60 minutes before and/or after the time ordered."</p> <p>2.) The clinical record for Resident #14 was reviewed on 3/13/14 at 12:05 p.m. Diagnoses for Resident #14 included, but were not limited to, diabetes mellitus, diabetic retinopathy, and dementia.</p> <p>A physician's order, dated 2/20/14, indicated Resident #14 was to receive 8 units of Novolog insulin daily with the noon meal.</p> <p>During a med pass observation on 3/13/14 at 11:35 a.m., LPN #2 was observed to give Resident #14 six units of Novolog insulin instead of the 8 units ordered by the physician.</p> <p>LPN #2 was interviewed on 3/13/14 at 1:25 p.m. LPN #2 indicated she had given the resident 6 units of Novolog insulin with the noon meal instead of the 8 units as ordered by the physician.</p> <p>The DoN was interviewed on</p>				

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	<p>3/14/14 at 9:40 a.m. She indicated the physician had been notified of the insulin medication error on 3/13/14 and follow-up accuchecks had been completed.</p> <p>Review of the current, undated, facility policy, titled "Injections, Insulin", provided by the DoN on 3/14/14 at 10:50 a.m., included, but was not limited to, the following:</p> <p>"Purpose:</p> <p>Insulin is injected to aid oxidation and utilization of the blood sugar by the tissues, and to control blood sugar levels in residents with Diabetes Mellitus.</p> <p>Policy:</p> <p>Insulin is administered by licensed personnel as ordered by the physician...."</p> <p>This deficiency was cited on 1/27/14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-48(c)(1)</p>				

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F000520 SS=D	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the Quality Assurance Committee identified medication pass concerns in regards to incorrect dosages and/or omitted medications following a federal citation during the annual survey resulting in a repeat deficiency with a medication pass error rate of 5.8%.</p>	F000520	<p>1. Corrective actions as described in the Plan of Correction were taken for Resident #14 and #9 related to receiving medications per physician's orders 2. As all residents could be affected, the following corrective action(s) have been taken. 3. Administrative staff have reviewed the current Quality Assurance Committee procedures, adding monthly meetings (exceeding the quarterly requirement) to include audits of specific care areas including, but not limited to,</p>	04/03/2014	

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	<p>Findings include:</p> <p>1.) The clinical record for Resident #14 was reviewed on 3/13/14 at 12:05 p.m. Diagnoses for Resident #14 included, but were not limited to, diabetes mellitus, diabetic retinopathy, and dementia.</p> <p>A physician's order, dated 2/20/14, indicated Resident #14 was to receive 8 units of Novolog insulin daily with the noon meal.</p> <p>During a med pass observation on 3/13/14 at 11:35 a.m., LPN #2 was observed to give Resident #14 six units of Novolog insulin instead of the 8 units ordered by the physician.</p> <p>LPN #2 was interviewed on 3/13/14 at 1:25 p.m. LPN #2 indicated she had given the resident 6 units of Novolog insulin with the noon meal instead of the 8 units as ordered by the physician.</p> <p>2.) During a medication administration observation on 3/13/14 at 3:45 p.m., Resident #9 was given 1 tablet Ferrex (iron) 150 mg, 1 tablet Os-cal with vitamin D 500 mg and artificial tear drops, 1 drop in each eye. LPN #1 exited Resident #9's room and indicated</p>		<p>medication administration per physicians orders. Administrative nursing shall be responsible to conduct and/or delegate said audits in an effort to identify quality of care areas of concern and address with the QA committee in an effort to formulate an action plan should deficient practice be identified. 4. As a means of quality assurance, the DON shall report findings of aforementioned audits and immediate corrective actions taken to the QA committee during monthly meetings. Further corrective action shall be planned/executed by the committee as warranted with follow up reporting provided/reviewed at the next Quality Assurance meeting in an effort to continually identify issues with respect to which quality assessment and assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality concerns</p>		

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	<p>she was finished.</p> <p>During medication reconciliation on 3/13/14 at 4:10 p.m., the physician order's indicated Reglan (medication used to treat heartburn) 5 mg should have been given with the 4:00 p.m. medication pass. The Director of Nursing (DoN) was asked to verify the Medication Administration Record and omission of the medication.</p> <p>During an interview on 3/14/14 at 10:10 a.m., the Assistant Director of Nursing (ADoN) indicated LPN #1 verbalized she omitted the Reglan.</p> <p>3.) The Administrator was interviewed on 3/14/14 at 12:50 p.m. He indicated the last quality assurance committee review of the medication pass process in regards to giving the correct medication was completed during the October, November, and December 2013 time period and was reviewed during the 1/29/14 Quality Assurance Committee meeting.</p> <p>He indicated the most recent facility focus had been on insulin timing concerns identified during the recent annual survey.</p>				

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	The facility failed to develop a systemic plan of correction to prevent recurrence of facility medication errors. 3.1-52(b)(2)				