

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155572	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  03/04/2015
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NAME OF PROVIDER OR SUPPLIER  APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F 000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00168674.</p> <p>Survey dates: February 25, 26, 27, March 2, 3, and 4, 2015.</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Survey team: Heather Hite, RN, TC Jennifer Redlin, RN Julie Ferguson, RN (February 26, 27, March 2, 3, &amp; 4, 2015) Caitlyn Doyle, RN (February 25, 26, 27, March 2 &amp; 3, 2015)</p> <p>Census bed type: SNF/NF: 64 Residential: 6 Total: 70</p> <p>Census Payor type: Medicare: 14</p>	F 000		
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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 156 SS=C Bldg. 00	<p>Medicaid: 37 Other: 13 Total: 64</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 11, 2015, by Janelyn Kulik, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p>				

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	<p>inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident</p>			

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	<p>abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure the residents were aware of who the Ombudsman was and how to contact the Ombudsman. This had the potential to affect the 64 residents who resided in the facility. (Residents #4, #18 and #31)</p> <p>Findings include:</p> <p>Interview with Resident #4 on 3/3/15 at 2:13 p.m., indicated that she did not who or what the Ombudsman (a resident advocate) was or how to contact the Ombudsman. She further indicated she attended the Resident Council meetings regularly and information on the Ombudsman had not been discussed.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 11/12/14 for Resident</p>	F 156	<p><b>F156</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state</i></p>	03/30/2015

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	<p>#4, indicated a BIMS (Brief Interview for Mental Status) score of 15. This indicated the resident was cognitively intact.</p> <p>Interview with Resident #18 on 3/3/15 at 3:10 p.m., indicated she was aware who the area ombudsman was but did not know how to contact him. She further indicated she attended the Resident Council meetings regularly and information on the Ombudsman had not been discussed.</p> <p>The Quarterly MDS assessment dated 12/4/14 for Resident #18, indicated a BIMS score of 15. This indicated the resident was cognitively intact.</p> <p>Interview with Resident #31 on 3/3/15 at 3:15 p.m., indicated she did not who or what the Ombudsman was or how to contact the Ombudsman. She further indicated she attended the Resident Council meetings regularly and information on the Ombudsman had not been discussed.</p> <p>The Quarterly MDS assessment dated 2/5/15 for Resident #31, indicated a BIMS score of 15. This indicated the resident was cognitively intact.</p> <p>Review of the Resident Council meeting</p>		<p><i>law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Monthly resident council meeting will be held on 3/25/15 with Ombudsman Dennis Fagan present.</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>Unable to determine to residents affected. Facility did not ensure the residents were aware of who the Ombudsman was and how to contact the Ombudsman.</b></p> <p><b>2) Measures put into place/ System changes:</b></p>	

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F 242 SS=D Bldg. 00	minutes from September 2014 to February 2015 on 3/3/15 at 2:30 p.m., indicated there was no discussion about the Ombudsman.  Interview with the Activity Director on 3/3/15 at 2:36 p.m., indicated she was unaware if the Ombudsman had ever been discussed at the Resident Council meetings.  3.1-4(j)(3)(C)  483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside		<b>Activity Director in serviced regarding resident notification pertaining to the Local Ombudsman. An audit will be completed monthly times 3 months to ensure all affected residents are notified who the Ombudsman is and how to contact the Ombudsman. The HFA will be responsible for these audits .</b>  <b>4) How the corrective actions will be monitored:</b>  The results of these audits will be reviewed in Quality Assurance Meeting monthly x3  Months, then quarterly x1 for a total of 6 months.  <b>5) Date of compliance: 3/30/2015</b>				

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	<p>and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on record review and interview, the facility failed to ensure resident individual preferences were followed, related to not giving the resident a choice of the amount of bathing she would prefer, for 2 of 4 residents reviewed for choices of the 4 who met the criteria for choices. (Residents #18 and #84)</p> <p>Findings include:</p> <p>1. During an interview on 2/26/15 at 10:53 a.m., Resident #18 indicated she had not been given a choice for the frequency of showers she would like to receive. She indicated the facility had a shower schedule and she was scheduled for twice a week. The resident indicated she would prefer to receive a shower three times a week.</p> <p>Resident #18's record was reviewed on 3/2/15 at 3:43 p.m. The resident's diagnoses included, but were not limited to, depressive disorder and hypertension.</p> <p>The Annual MDS (Minimum Data Set) assessment, dated 6/5/14, indicated the resident was cognitively intact and it was very important to her to choose her type of bathing.</p>	F 242	<p><b>F 242</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Shower schedule has been updated for affected residents</b></p>	03/30/2015			

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	<p>Review of the "Unit: North Pocket Worksheet", received from the Director of Nursing (DON) as current, indicated the resident was scheduled for a shower on Tuesday and Friday during the evening shift.</p> <p>Review of the "Showers and Shampoos" log for February 2014, indicated the resident had received a shower twice a week on Tuesday and Friday evenings.</p> <p>Review of a "Choices-Personal Preferences" form, dated 7/17/13, indicated the resident preferred a shower and the facility shower schedule was acceptable to her. There was lack of documentation in the resident record to indicate the resident's bathing preferences had been discussed since 7/17/13.</p> <p>During an interview on 3/3/15 at 9:49 a.m., the Social Service Director (SSD) indicated she had gone over preferences with the residents and would then give the information to the Assistant Director of Nursing (ADON). She further indicated she was unsure what the ADON then did with the information.</p> <p>During an interview on 3/3/15 at 9:57 a.m., the DON indicated the SSD asked the residents preferences questions and</p>		<p><b>2) How the facility identified other residents:</b></p> <p>Interviews have been done with all residents and/or their family to identify their preferences.</p> <p><b>3) Measures put into place/ System changes:</b></p> <p>Staff have been in-serviced on Resident Choices.</p> <p>Preference interviews will be done for each resident at admission during MDS assessment period and quarterly thereafter. Shower days will be adjusted to meet the residents' preferences. Social Service Director will be responsible for the oversight and pick three residents weekly to audit their preferences.</p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>	

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	<p>would give the information to the ADON. She further indicated the ADON was not currently in the facility but she would call her to get the information.</p> <p>Continued interview on 3/3/15 at 1:33 p.m. with the DON, indicated Resident #18 was admitted to the facility back on 2004. She indicated she had no record of what the resident's bathing preferences were at that time. She further indicated resident preferences were gone over specifically upon admission but at care plan meetings completed quarterly resident's are asked if everything was going ok.</p> <p>Continued interview on 3/3/15 at 2:19 p.m. with the SSD, indicated she asked residents preferences and choices questions only on admission, not annually.</p> <p>2. Interview with Resident #84 on 2/26/15 at 11:13 a.m., indicated he received one shower a week but preferred to take three showers a week.</p> <p>Record review for Resident #84 was completed on 2/27/15 at 9:28 a.m. The diagnoses included, but were not limited to, hypertension, arthritis, cerebral vascular accident (stroke) and muscle weakness.</p>		<p><b>5) Date of compliance:</b></p> <p><b>3/30/2015</b></p>	

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	<p>The Admission MDS (Minimum Data Set) assessment dated 1/23/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 12. This indicated the resident was cognitively intact. The ADLs (Activities of Daily Living) section indicated the resident required supervision from staff for bathing. The assessment indicated it was somewhat important for the resident to choose between a tub bath, shower, bed bath, or sponge bath.</p> <p>An Activity Assessment completed on 1/15/15, indicated it was somewhat important for the resident to choose bathing preference and that he preferred to take showers.</p> <p>A Social Service History/Initial assessment completed on 1/16/15 indicated the resident's method of bathing as an adult was to take a shower 3 times a week in the daytime.</p> <p>A West Hall Pocket Worksheet dated 2/25/15, that was used by the CNAs indicated the resident was an assist of 1 person and was to receive a shower on Tuesdays and Fridays every week.</p> <p>Interview with Restorative CNA #1 on 2/27/15 at 9:59 a.m., indicated when the residents were admitted they were put on</p>			

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	<p>a shower schedule made by the ADON (Assistant Director of Nursing) and the CNAs were aware of the days by looking at the Hall Pocket Worksheet.</p> <p>Interview with the DON (Director of Nursing) on 2/27/15 at 10:05 a.m., indicated when residents were admitted the SSD (Social Service Director) would go over a preference list for showers and then give it to the ADON.</p> <p>Interview with the SSD on 10/27/15 at 10:19 a.m., indicated when residents were admitted she would go over a preference list with them that indicated what type of bathing and frequency they would prefer. She further indicated she would then give the assessment to the ADON and the ADON would then put the residents on a shower schedule according to their preference.</p> <p>Interview with the ADON on 2/27/15 at 10:15 a.m., indicated she would get a copy of the bathing assessment from the SSD and then put the residents on a schedule according to their preferences. She indicated she must of made a mistake when making the schedule for Resident #84. She further indicated the Pocket Worksheet for the CNAs should have indicated Resident #84 to have a shower 3 times a week instead of 2 showers a</p>			

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F 280 SS=D Bldg. 00	<p>week.</p> <p>3.1-3(u)(1)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on record review and interview, the facility failed to ensure a resident's Responsible Party had been invited to participate in the resident's care plan reviews and failed to ensure care plan reviews were completed in a timely manner for 1 of 1 resident reviewed for participation in care planning. (Resident #2)</p> <p>Finding includes:</p>	F 280	<p><b>F 280 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of</b></p>	03/30/2015

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	<p>An interview with Resident #2's family member on 2/26/15 at 10:55 a.m., indicated she received a letter to attend a care plan meeting a year ago, but had not received any invitation since then.</p> <p>Record review for Resident #2 was completed on 2/27/15 at 10:24 a.m. The resident's diagnoses included, but were not limited to, hypertension, dementia and arthritis.</p> <p>A Significant Change MDS (Minimum Data Set) assessment dated 1/28/15 indicated a BIMS (Brief Interview for Mental Status) score of 5. This indicated the resident was cognitively impaired.</p> <p>A review of the Care Conference Reports indicated the resident had a Care Plan meeting held on 4/1/14, 10/2/14, 11/20/14, and 12/11/14. A review of SS (Social Service) Notes from 4/2/14 to 10/1/14 indicated the resident did not have a care plan meeting held during this time.</p> <p>Interview with the SSD (Social Services Director) on 2/27/15 at 11:29 a.m., indicated she sends out invitations in the mail to families for the Care Plan Meetings. She indicated Care Plan conferences were held at least every 3</p>		<p><i>correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) Immediate actions taken for those residents identified: Care Plan Meeting invitation has been sent to the family of Resident #2. 2) How the facility identified other residents: An audit has been completed of care plan reviews in the last 30 days and care plan reviews due in the next 30 days. Care plan invitations will be sent to all resident/families as identified. 3) Measures put into place/ System changes: Care Plan invitations will be provided to resident and/or family/legal representative at least quarterly, and will be documented in resident record. An audit will be completed of at least 3 residents per week who had an MDS completed the previous week to ensure notice was provided. Social Service Director will be responsible for oversight of these audits. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 3/30/2015.</i></p>		

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NAME OF PROVIDER OR SUPPLIER  APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
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F 282 SS=D Bldg. 00	<p>months unless there was a significant change with the resident or the family requests one. If that happens then a meeting maybe held sooner than 3 months.</p> <p>Interview with the SSD on 2/27/15 at 12:30 p.m., indicated she had no proof Resident #2's family was invited to the Care Plan Meetings for 2014. The last letter of invitation she could find that was sent to the family was from September 10, 2013.</p> <p>Interview with the SSD on 3/2/15 at 12:08 p.m., indicated prior to the care plan meeting in October 2014, Resident #2 had one completed in April of 2014. She further indicated the resident should of had another one held in between April 2014 and October 2014 but she could not find any information one was held.</p> <p>3.1-35(d)(2)(B)</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 observation, record review, and interview, the facility failed to ensure the</p>	F 282	<b>F 282 The facility requests paper compliance for this</b>	03/30/2015	

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	<p>current plan of care was followed as written related to a residents bathing schedule for 1 of 3 residents reviewed for Activities of Daily Living of the 3 who met the criteria for Activities of Daily Living and for wound care treatments not completed as ordered for 1 of 3 residents reviewed for Pressure Ulcers of the 3 who met the criteria for Pressure Ulcers. (Resident's #5 and #9)</p> <p>Findings include:</p> <p>1. Observation on 2/25/15 at 3:31 p.m., Resident #5 was laying in bed. The resident's fingernails were observed to be long, yellow, and have black/brown colored debris underneath the fingernails. Interview with the resident at the time indicated staff sometimes cleaned her nails when she got bathed but she had not been bathed this week.</p> <p>Observation on 2/27/15 at 9:17 a.m., Resident #5 was laying in bed. The resident's fingernails were observed to be long, yellow, and have black/brown colored debris underneath the fingernails.</p> <p>Observation on 3/2/15 at 11:10 a.m., Resident #5 was laying in bed. The resident's fingernails were observed to be long, yellow, and have black/brown colored debris underneath the fingernails.</p>		<p><b>citation.</b> <i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i></p> <p><b>Immediate actions taken for those residents identified:</b> Resident #5 had nails cleaned by nursing assistant. Resident #9 was discharged from this facility in November 2014 2)</p> <p><b>How the facility identified other residents:</b> Managers performed rounds on residents and looking at fingernails was included in rounds. Residents that managers found to have dirty fingernails were communicated to nursing assistants. Nurses were also made aware of residents so that they could follow up with nursing assistants if nail care was completed. Managers then made another round on residents identified a few hours later to assure nail care had been completed. Residents who currently are receiving treatments for wounds had their wound orders audited to ensure they were put incorrectly. 3) <b>Measures put into</b></p>		

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	<p>Record review for Resident #5 was completed on 3/2/15 at 10:00 a.m. The resident's diagnoses included, but were not limited to, hypertension, depression, and hemiplegia.</p> <p>A Care Plan dated 8/22/14 indicated: Resident had not been getting up, stays in bed most of the day. Resident had lost trust in staff and was wary of letting them bath her as she was not comfortable. Interventions included: Resident has agreed to 1 shower a week and bed baths the rest of the week.</p> <p>A West Hall Pocket Worksheet for CNAs dated 2/25/15 indicated the resident had a shower scheduled on Tuesdays and Fridays on midnights.</p> <p>Review of the bathing log for February 2015 indicated the resident received a complete bed bath or shower twice a week on Tuesdays and Fridays.</p> <p>Interview with LPN #1 on 3/2/15 at 11:12 a.m., indicated the resident gets a shower twice a week.</p> <p>Interview with CNA #1 on 3/2/15 at 11:16 a.m., indicated the resident gets bathed twice a week on midnight shift.</p>		<p><b>place/ System changes:</b> Nursing staff were in-serviced on importance of nail care. DON or designee will observe the condition of 5 residents nailstwicely weekly. All new treatment orders received will be audited the next business day to ensure that they are put into the computer correctly so that they show up on the treatment administration record (TAR) and/or medication administration record (MAR) so that they may be signed by licensed personnel administering medication or treatment. Orders that are found to be input incorrectly will be corrected when found unless clarification is needed by MD. If clarification is needed by the MD the floor nurse will be made aware to obtain clarification and to correct the order. Orders that were corrected will be audited again the next day to ensure that they are now input correctly. These audits will be completed by DON or designee at least once weekly. <b>4)</b> <b>How the corrective actions will be monitored:</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. <b>5)</b> <b>Date of compliance: 3/30/2015</b></p>				

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	<p>Interview with the DON (Director of Nursing) on 3/2/15 at 1:52 p.m., indicated the resident was supposed to get bed baths everyday according to her Care Plan because she did not like to leave her room. She indicated the Hall Pocket Worksheet was incorrect to have bathing on Tuesday and Friday only. She further indicated the Hall Pocket Worksheet for the CNAs will have to be updated to reflect the residents Care Plan so they know to bathe the resident everyday.</p> <p>2. Resident #9's closed record was reviewed on 3/2/15 at 2:50 p.m. Diagnoses included, but were not limited to, aftercare healing traumatic fracture lower leg, muscle weakness, rehabilitation, peripheral neuropathy (nerve disease or damage), peripheral vascular disease, diabetes mellitus and rheumatoid arthritis.</p> <p>The Admission Assessment dated 10/14/14 indicated a suspected deep tissue injury (DTI) pressure area to the right heel measuring 6.0 x 8.0 with 100% eschar (dead tissue that falls away from healthy skin).</p> <p>The Physician's Orders for October and November 2014 included the following orders related to treatment of the right</p>			

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	<p>heel pressure area:</p> <ul style="list-style-type: none"> <li>- 10/16/14 Cleanse R (right) heel with wound cleanser, pat dry, apply Betadine swab then wrap with kerlix daily.</li> <li>- 10/20/14 Santyl ointment - apply to R heel topically every day and evening shift for wound healing, cleanse R heel with wound cleanser, pat dry, apply Santyl, nickel thick cover with gauze &amp; secure with kerlix twice daily and as needed for soilage or dislodgement.</li> <li>- 10/25/14 Santyl ointment apply to right heel topically two times a day r/t (related to) diabetes mellitus</li> <li>- 11/12/14 Santyl ointment - apply to right heel topically every day shift related to diabetes mellitus, cleanse with wound cleanser, apply Santyl, cover with telfa and dry dressing</li> </ul> <p>Review of the Treatment Administration Records (TARs) for October and November 2014 lacked documentation to indicate the treatments to the right heel pressure wound were completed as ordered on the following shifts:</p> <ul style="list-style-type: none"> <li>10/23/15 days</li> <li>10/25/14 evenings</li> <li>10/30/14 days</li> <li>10/30/14 evenings</li> <li>11/1/14 evenings</li> </ul> <p>There was also missing documentation for all "Cleanse R (right) heel with wound cleanser, pat dry, apply Betadine</p>			

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F 312 SS=D Bldg. 00	<p>swab then wrap with kerlix daily" treatments from 10/16 - 10/21/14.</p> <p>Interventions on the care plan for "pressure ulcer present to right heel upon admission" included, but were not limited to, meds as ordered - observe for side effects and effectiveness and treatments as ordered - assess for effectiveness.</p> <p>Interview with the Nurse Consultant on 3/3/15 at 3:25 p.m. indicated, "There was a problem with the order entry for the "Cleanse R (right) heel with wound cleanser, pat dry, apply Betadine swab then wrap with kerlix daily" treatments from 10/16 - 10/21/14 which wouldn't allow it to come up as signed off, resulting in no charting of treatments completed for those 5 days on the TAR."</p> <p>Interview with the DON on 3/4/2015 12:15 p.m., indicated she was unable to produce documentation to indicate the right heel wound treatments were completed as ordered on 10/23/15 days, 10/25/14 evenings, 10/30/14 days, 10/30/14 evenings &amp; 11/1/14 evenings.</p> <p>3.1-35(g)(2)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p>						

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	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, record review and interview, the facility failed to provide Activities of Daily Living (ADL) assistance to a dependant resident related to unclean fingernails and providing bathing as scheduled for 1 of 3 residents reviewed for Activities of Daily Living of the 3 who met the criteria for Activities of Daily Living. (Resident #5)</p> <p>Finding includes:</p> <p>Observation on 2/25/15 at 3:31 p.m., Resident #5 was laying in bed. The resident's fingernails were observed to be long, yellow, and have black/brown colored debris underneath the fingernails. Interview with the resident at the time indicated staff sometimes cleaned her nails when she got bathed but she had not been bathed this week.</p> <p>Observation on 2/27/15 at 9:17 a.m., Resident #5 was laying in bed. The resident's fingernails were observed to be long, yellow, and have black/brown colored debris underneath the fingernails.</p> <p>Observation on 3/2/15 at 9:01 a.m., Resident #5 was laying in bed. The</p>	F 312	<p><b>F 312</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Shower was given to resident</b></p>	03/30/2015	

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	<p>resident's fingernails were observed to be long, yellow, and have black/brown colored debris underneath the fingernails.</p> <p>Observation on 3/2/15 at 11:10 a.m., Resident #5 was laying in bed. The resident's fingernails were observed to be long, yellow, and have black/brown colored debris underneath the fingernails.</p> <p>Record review for Resident #5 was completed on 3/2/15 at 10:00 a.m. The resident's diagnoses included, but were not limited to, hypertension, depression, and hemiplegia.</p> <p>The Quarterly MDS (Minimum Data Set) assessment dated 1/29/15, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 13. This indicated the resident was cognitively intact. The ADLs (Activities of Daily Living) section indicated the resident was an extensive 2+ person for personal hygiene and was a total dependence of 2+ person assist for bathing. The resident had a functional limitation in range of motion that affected her upper and lower extremity on one side of her body.</p> <p>A Care Plan dated 8/22/14 indicated: Resident had not been getting up, stays in bed most of the day. Resident had lost trust in staff and was wary of letting them</p>		<p><b>2) How the facility identified other residents:</b></p> <p><b>Audit of showers for March completed to identify any other residents affected.</b></p> <p><b>3) Measures put into place/ System changes:</b></p> <p><b>Nursing staff have been educated on the importance of bathing residents per schedule.</b></p> <p><b>Bathing documentation will be reviewed on a minimum of 5 residents per week to ensure bathing and nail care schedules are followed. Any discrepancies will be addressed with appropriate education/counseling.</b></p> <p><b>The Director of Nursing or designee will be responsible for oversight of these audits.</b></p> <p><b>4) How the corrective actions will be monitored:</b></p>		

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	<p>bath her as she was not comfortable. Interventions included: Resident has agreed to 1 shower a week and bed baths the rest of the week.</p> <p>A West Hall Pocket Worksheet for CNAs dated 2/25/15 indicated the resident had a shower scheduled on Tuesdays and Fridays on midnights.</p> <p>Review of the bathing log for February 2015 indicated the resident received a complete bed bath or shower twice a week on Tuesdays and Fridays.</p> <p>Interview with LPN #1 on 3/2/15 at 11:12 a.m., indicated the resident gets a shower twice a week. She indicated the CNAs and nurses do nail care. She further indicated the staff should have noticed the resident's nails were dirty and cleaned them with her shower or routine ADL care.</p> <p>Interview with CNA #1 on 3/2/15 at 11:16 a.m., indicated the resident gets bathed twice a week on midnight shift. She indicated residents get nail care completed by the CNAs and nursing. She further indicated the resident should have gotten her nails cleaned with her shower.</p> <p>Interview with the DON (Director of</p>				<p><b>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</b></p> <p><b>5) Date of compliance:</b>  <b>3/30/2015</b></p>		

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F 314 SS=D Bldg. 00	<p>Nursing) on 3/2/15 at 1:52 p.m., indicated the resident was supposed to get bed baths everyday according to her Care Plan because she did not like to leave her room. She indicated staff should have noticed the residents nails were dirty and cleaned them with normal ADL care or when she was bathed. She indicated the Hall Pocket Worksheet was incorrect to have bathing on Tuesday and Friday only. She further indicated the Hall Pocket Worksheet for the CNAs will have to be updated to reflect the residents Care Plan so they know to bathe the resident everyday.</p> <p>3.1-38(a)(2)(A) 3.1-38(a)(3)(E)</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on record review and interview,</p>	F 314	<b>F 314 The facility requests paper compliance for this citation. This Plan of</b>	03/30/2015

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	<p>the facility failed to ensure the necessary treatments and services to treat pressure ulcers were provided related to not completing treatments as ordered by the Physician for 1 of 3 residents reviewed for pressure ulcers of the 3 who met the criteria for pressure ulcers. (Resident #9)</p> <p>Finding includes:</p> <p>Resident #9's closed record was reviewed on 3/2/15 at 2:50 p.m. Diagnoses included, but were not limited to, aftercare healing traumatic fracture lower leg, muscle weakness, rehabilitation, peripheral neuropathy (nerve disease or damage), peripheral vascular disease, diabetes mellitus and rheumatoid arthritis.</p> <p>The Admission Assessment dated 10/14/14 indicated a suspected deep tissue injury (DTI) pressure area to the right heel measuring 6.0 x 8.0 with 100% eschar (dead tissue that falls away from healthy skin).</p> <p>The Physician's Orders for October and November 2014 included the following orders related to treatment of the right heel pressure area:</p> <p>- 10/16/14 Cleanse R (right) heel with wound cleanser, pat dry, apply Betadine swab then wrap with kerlix daily.</p>		<p><i>Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1)</i></p> <p><b>Immediate actions taken for those residents identified:</b> Resident #9 was discharged from this facility in November 2014</p> <p><b>2) How the facility identified other residents:</b> Residents who currently are receiving treatments for wounds had their wound orders audited to ensure they were put in correctly.</p> <p><b>3) Measures put into place/ System changes:</b> All new treatment orders received will be audited the next business day to ensure that they are put into the computer correctly so that they show up on the treatment administration record (TAR) and/or medication administration record (MAR) so that they may be signed by licensed personnel administering medication or treatment. Orders that are found to be input incorrectly will be corrected when found unless clarification is needed by MD. If clarification is needed by the MD the floor nurse will be made aware to obtain</p>				

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	<p>- 10/20/14 Santyl ointment - apply to R heel topically every day and evening shift for wound healing, cleanse R heel with wound cleanser, pat dry, apply Santyl, nickel thick cover with gauze &amp; secure with kerlix twice daily and as needed for soilage or dislodgement.</p> <p>- 10/20/14 AFO boot to remain in place at all times except for hygiene and dressing changes</p> <p>- 10/24/14 Promod (protein supplement) 30 cc po (by mouth) bid (twice daily) - wound healing</p> <p>- 10/25/14 Santyl ointment apply to right heel topically two times a day r/t (related to) diabetes mellitus</p> <p>- 11/12/14 Santyl ointment - apply to right heel topically every day shift related to diabetes mellitus, cleanse with wound cleanser, apply Santyl, cover with telfa and dry dressing</p> <p>Review of the Treatment Administration Records (TARs) for October and November 2014 lacked documentation to indicate the treatments to the right heel pressure wound were completed as ordered on the following shifts: 10/23/15 days 10/25/14 evenings 10/30/14 days 10/30/14 evenings 11/1/14 evenings There was also missing documentation</p>		<p>clarification and to correct the order. Orders that were corrected will be audited again the next day to ensure that they are now input correctly. These audits will be completed by DON or designee at least once weekly. <b>4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. <b>5) Date of compliance: 3/30/2015</b></p>		

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	<p>for all "Cleanse R (right) heel with wound cleanser, pat dry, apply Betadine swab then wrap with kerlix daily" treatments from 10/16 - 10/21/14.</p> <p>Review of the Pressure Ulcer Progress Reports for the right heel indicated the following:</p> <ul style="list-style-type: none"> <li>- 10/22/14: measures 10.6 cm (centimeters) x 9.5 cm, suspected DTI, 100% eschar, Santyl cover w/ kerlix, health shake, foot/heel protector</li> <li>- 10/29/14 : measures 8.6 cm x 7.5 cm, suspected DTI, 100% black, Santyl cover with kerlix BID, protein supplement, MVI, specialized bed surface</li> <li>- 11/5/14: measures 10.5 cm x 8.0 cm, 100% eschar, Santyl cover with kerlix BID</li> <li>- 11/12/14: measures 10.0 cm x 8.0 cm, suspected DTI, area blackened, odor noted with dressing change, cleanse, apply Santyl and cover with kerlix dressing, scheduled to have area debrided on 11/13/14, protein supplement, specialized bed surface, foot/heel protectors, positioning pillows, turning/positioning program, dietary notified</li> </ul> <p>Interventions on the care plan for "pressure ulcer present to right heel upon admission" included, "meds as ordered - observe for side effects and effectiveness</p>			

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	<p>and treatments as ordered - assess for effectiveness; AFO boot to right heel; cushion in w/c (wheelchair); notify family of any new areas of skin breakdown; notify nurse of any new areas of skin breakdown: redness, blisters, discoloration noted during bath or daily care; observe nutritional status, diet as ordered, monitor &amp; record meal intake; pressure reducing mattress; provide supplemental protein, amino acids, vitamins, minerals as ordered to promote wound healing; weekly skin assessments per facility policy."</p> <p>Interview with the current Wound Nurse on 3/03/15 at 10:05 a.m., indicated 11/5/14 was the first time she had measured the resident's right heel wound and another nurse had measured previously. Interventions included to float heels and wear a protective boot. She further indicated the wound seemed about the same the couple times she had seen the wound, maybe slightly better on 11/12/14. The resident then went to have the area debrided (surgical removal of dead tissue)and didn't return. The resident was seeing a wound specialist in South Bend for treatment.</p> <p>Interview with the Nurse Consultant on 3/3/15 at 3:25 p.m. indicated, "There was a problem with the order entry for the</p>			

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F 332 SS=D Bldg. 00	<p>"Cleanse R (right) heel with wound cleanser, pat dry, apply Betadine swab then wrap with kerlix daily" treatments from 10/16 - 10/21/14 which wouldn't allow it to come up as signed off, resulting in no charting of treatments completed for those 5 days on the TAR."</p> <p>Interview with the DON on 3/4/2015 12:15 p.m., indicated she was unable to produce documentation to indicate the right heel wound treatments were completed as ordered on 10/23/15 days, 10/25/14 evenings, 10/30/14 days, 10/30/14 evenings &amp; 11/1/14 evenings.</p> <p>3.1-40(a)(2)</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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5%, related to not flushing a Percutaneous Endoscopic Gastrostomy (PEG) tube properly and administering three crushed medications mixed together into a PEG tube for 1 of 4 residents observed during</p>	F 332	<p>F 332</p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the</i></p>	03/30/2015			

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	<p>medication pass. Three errors were observed during 26 opportunities for errors during medication administration resulting in an error rate of 11.5%. (Resident #B)</p> <p>Findings include:</p> <p>1. LPN #1 was observed on 2/26/15 at 4:04 p.m. during a medication administration through Resident #B's PEG tube. LPN #1 washed her hands, applied gloves, stopped the feeding pump, unattached the feeding pump tubing from the PEG tube, and removed a syringe with a plunger from an undated plastic bag stored in the bedside dresser. She then administered a 30 cc (cubic centimeter) air bolus through the PEG tube with the syringe after she had placed her stethoscope next to the resident's stoma (where the tube was placed in the stomach area for access to the tube feeding) to check for placement of the PEG tube. LPN #1 then removed the plunger from the syringe while it remained attached to the tube and placed it on the resident's bedspread and administered 15 cc of water through the tube via gravity. LPN #1 then proceeded with the medication administration.</p> <p>Interview with the DON on 2/27/15 at 1:21 p.m., indicated the nurse should have flushed with 30 cc of water before</p>		<p><i>center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Nurses were one on one in-serviced about proper medication administration via PEG tube and a new syringe was placed at bedside.</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>There was only one resident in the facility that had the potential to be affected.</b></p> <p><b>3) Measures put into place/ System changes:</b></p>		

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	<p>administering medications.</p> <p>2. While RN #1 prepared Resident #B's PEG tube medications on 2/27/15 at 10:00 a.m., the following was observed: RN #1, without having used hand sanitizer or washing her hands prior to or between each medication, punched out each of the following tablet medications with her bare hands: escitalopram (antidepressant), furosemide (diuretic), and metoprolol tartrate (to treat high blood pressure). RN #1 placed each of the medications into a pouch with her bare hands and proceeded to crush all three medications in the pouch, then placed them in a medication cup for administration. RN #1 went to the resident's room, checked the placement of the resident's PEG tube, then added 20 cc of water into the crushed medication cup and set it aside. RN #1 administered the crushed dissolved tablet mixture, then added 5 cc of water into the syringe to flush the medication.</p> <p>Interview on 2/27/15 with RN #1 at 10:30 a.m., indicated it was normal practice to crush the PEG tube tablets together and administer.</p> <p>Interview with the DON (Director of Nursing) on 2/27/15 at 11:50 a.m., indicated the nurse should have</p>		<p><b>At this time there are currently no residents in the facility that receive medications via PEG tube. In the event that a resident with a PEG tube is admitted competency checks will be completed by DON or designee on varied shifts.</b></p> <p><b>4) How the corrective actions will be monitored:</b></p> <p><b>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</b></p> <p><b>5) Date of compliance: 3/30/2015</b></p>	

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	<p>administered each tablet medication individually into the PEG tube and should not have crushed the tablets together in order to properly flush each medication individually.</p> <p>Interview with the DON on 2/27/15 at 1:21 p.m., indicated the nurse should have flushed with 30 cc of water before administering medications.</p> <p>The record for Resident #B was reviewed on 2/26/15 at 4:45 p.m. The diagnoses included, but were not limited to, hemiplegia, dysphagia, muscle weakness, and epilepsy.</p> <p>The Physician Order Summary for February 2015 was reviewed and indicated NPO (nothing by mouth), furosemide tablet give 20 mg via PEG tube one time a day, metoprolol tartrate tablet give 50 mg via PEG tube two times a day, Lexapro tablet(escitalopram oxalate) 5 mg give 1 tablet by mouth one time day.</p> <p>A policy titled, " G tube-med admin," was provided by the Administrator on 2/27/15 at 11:20 a.m., and indicated "...Procedure: 10. Flush the feeding tube with 30 ml of water at room temperature before medication administration...12. Administer one medication at a time...."</p>			

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F 431 SS=E Bldg. 00	<p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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 records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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</p>			

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	<p>drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure medications were stored properly and safely on 3 of 4 medication carts. The facility also failed to ensure all medications were labeled properly according to current Physician's Orders. (ACU (Alzheimer's Care Unit), West Hall, and North Hall)</p> <p>Findings include:</p> <p>1. On 2/17/15 at 8:56 a.m. on the ACU, Resident #57's Namenda (memory medication) 10 mg (milligram) tablet punch card was observed sitting on top of the "South 2" medication cart in plain sight. The card had 1 tablet remaining. The nurse was not present on the unit at the time of the observation.</p> <p>Resident #28, cognitively impaired, was present and was observed to walk past the medication cart at 8:56 a.m. and again at 9:00 a.m. Another resident that resided in the ACU, Resident #33, also walked by the medication cart at 9:00 a.m.</p> <p>Interview on 2/27/15 at 9:06 a.m. with LPN #1, indicated the medication card was empty. She then looked at the</p>	F 431	<p><b>F 431</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b> Nurses were in-serviced one on one by the DON about proper storage of medication and about verifying that a medication card is in fact empty before placing it on top of the cart for disposal. Nurses were also in-serviced about not walking away from med carts with medication punch cards on top. Medication was labeled with a change of direction sticker.</p> <p><b>2) How the facility identified other residents:</b></p>	03/30/2015			

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	<p>Namenda medication card again and saw that 1 tablet remained. She further indicated medications were not to be left out on top of the medications carts and should be locked inside the cart.</p> <p>2. On 2/27/15 at 10:33 a.m. on the North Hall, Resident #36's Folic Acid 1 mg tablets were observed on top of medication cart. Two tablets remained in the Folic Acid punch card. The North Hall nurse was not within site of the medication cart at the time of the observation.</p> <p>Two CNAs passed by the medication cart at 10:34 a.m. The North Hall nurse, RN #2, walked out of room #16 and passed the cart at 10:34 a.m. and proceeded to the nurses' station. Two CNAs walked past the medication cart again at 10:35 a.m. RN #2 returned to the medication cart at 10:36 a.m. Interview with RN #2 at that time, indicated the medication should not have been left out on top of the medication cart and should have been locked inside the cart.</p> <p>Interview with the DON (Director of Nursing) on 2/27/15 at 11:50 a.m., indicated both nurses should not have left medications out on top their medication carts and the medications should have been locked in the cart.</p>		<p>Rounds were completed to ensure no other meds were left unattended on top of med carts. An audit was also completed of medications that require refrigeration were properly stored and of medications that recently had a change of directions. An audit was also performed on residents that have had dosage changes in the last 30 days.</p> <p><b>3) Measures put into place/ System changes:</b> The nurses and QMAs were in-serviced about proper medication storage, placing change of direction stickers, and what to do with medication punch cards when they are empty. Observations of med pass and cart audits will be completed randomly twice weekly by DON or designee. Orders will be reviewed at least three times a week by DON or designee for dosage changes and medication card will be audited for change of direction sticker as indicated. Nurses or QMAs found to not be following proper medication storage and disposal of empty medication punch cards will be in-serviced one on one by DON or designee who observed the error.</p> <p><b>4) How the corrective actions will be monitored:</b>  The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p>		

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	<p>A policy titled, "Pharmore Drugs," was provided by the Administrator on 2/17/15 at 11:30 a.m. was current and indicated, "...STORAGE OF MEDICATION CARTS 1. Medication carts shall be supervised by the charge nurse responsible for the cart at all times. 2. During the time that medications are not being passed, the medication cart and treatment carts should be locked and made immobile...."</p> <p>3. On 2/26/15 at 3:41 p.m., during a medication administration observation with LPN #1 on the West Hall, LPN #1 pulled Resident's #B lansoprazole (a medication to decrease stomach acid) medication to be administered from the cart drawer indicated on the label it was to be refrigerated.</p> <p>Interview with LPN #1 and the DON (Director of Nursing) on 2/26/15 at 4:51 p.m., indicated the medication should have been refrigerated.</p> <p>4. During a medication pass observation on 2/26/15 at 3:52 p.m. with LPN #1 on the West Hall, the medication label for Resident #B indicated Phenobarbital 32.4 mg give 2 tablets per g-tube once a daily.</p> <p>Review of the Physician's Order</p>		<p>months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance: 3/30/2015</b></p>	

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F 441 SS=E Bldg. 00	<p>Summary for February 2015 indicated Phenobarbital tablet 32.4 mg give 1 tablet via PEG tube one times a day.</p> <p>Interview with LPN #1 and the DON on 2/26/15 at 4:51 p.m., indicated there should have been a change in dosage sticker for Resident #B 's Phenobarbital.</p> <p>The policy titled, "Pharmore Drugs," was provided by the DON on 3/2/15 at 10:23 a.m. was current and indicated, "...LABEL DIRECTION CHANGES: 1. When the directions change on a medication, the pharmacy will not send a new label. Rather, the nurse receiving the directions change order should affix a 'Directions Changed-Refer to Chart' sticker to the bottom right hand corner of existing label...."</p> <p>3.1-25(j)(k)(l) 3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the</p>			

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	<p>development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices and standards were maintained related to bath basins and urinals stored uncovered on the bathroom floor, a syringe plunger used for a Percutaneous Endoscopic</p>	F 441	<p><b>F 441 The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the</b></p>	03/30/2015

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NAME OF PROVIDER OR SUPPLIER  APERION CARE DEMOTTE			STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310		
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	<p>Gastrostomy (PEG) tube placed on a resident's bed during a medication administration observation, an undated syringe for use with a resident's PEG tube, staff touching resident medications with bare hands prior to administration, lack of glove use by staff during insulin administration, and improper disposal of a glucometer test strip (a test strip used to test blood sugars). This had the potential to affect 5 residents that receive glucometer testing and 4 residents that receive insulin injections on the North Hall, and 2 residents with PEG tube medications. (West Hall, Resident #B, and Resident #22)</p> <p>Findings include:</p> <p>1. LPN #1 was observed on 2/26/15 at 4:04 p.m. during medication administration using Resident #B's PEG tube. LPN #1 administered a 30 cc (cubic centimeter) air bolus after she had placed her stethoscope next to the stoma (where tube was placed in the stomach area for tube feeding) to check for proper placement of the PEG tube. LPN #1 then removed plunger and placed it on the resident's bedspread, left the syringe in place in the tubing and administered 15 cc of water via gravity. She then pushed the water through the tube with the plunger, removed the plunger and placed</p>		<p><i>truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified: Nurses were one on one in-serviced about maintaining infection control practices during medication administration and preparation. A new syringe was obtained to replace the contaminated one. The bath basin and urinal were disposed of with new ones obtained. 2) How the facility identified other residents: All residents have the potential to be affected. 3) Measures put into place/ System changes: The nursing staff were in-serviced on maintaining infection control practices during medication preparation and administration. They were also in-serviced on the proper disposal of glucometer testing supplies. Nursing assistants were in-serviced on proper storage of bath basins and urinals. DON or designee will observe three medication passes on varied shifts. DON or designee will also monitor storage of bath basins and urinals five times weekly on varied shifts. 4) How the corrective actions will be</b></p>		

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	<p>it back on the resident's bedspread, administered the liquid lansoprazole (a medicine to decrease stomach acid) 10 ml (milliliters) with 5 cc of water added into the syringe to flush the medication, pushed it through with the plunger and then again placed the plunger back onto the resident's bedspread. After LPN #1 finished administering the remainder of the medications, she rinsed the syringe in the resident's sink, placed the plunger and syringe into a plastic bag, and stored the bag back in the resident's dresser.</p> <p>Interview with LPN #1 on 2/26/15 after the medication observation, indicated the 2-10 shift should have changed the syringe with plunger and dated it. She further indicated she should have placed a paper towel under the plunger and not laid the plunger directly on the resident's bedspread.</p> <p>Interview with the DON (Director of Nursing) on 2/27/15 at 1:21 p.m., indicated the syringes with plunger for PEG tubes should be replaced every 24 hours and should have been dated. She further indicated the plunger for the PEG tube syringe should not have been placed on the resident's bedspread and instead should have been placed on a paper towel.</p>		<p><b>monitored:</b> The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months. <b>5) Date of compliance: 3/30/2015</b></p>		

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	<p>A policy titled, "Irrigation Sets," was provided by the DON on 3/2/15 at 10:23 a.m., was current and indicated,"...General Guidelines: 1. Irrigation sets are to be used to assist with flushing of the peg tube and to assist with administering medications. 2. Irrigations sets are to be changed every 24 hours with the old set being disposed of. 3. Irrigation sets will be initialed and dated by the person replacing it. 4. If any part of the irrigation set become contaminated it will be immediately replaced..."</p> <p>2. While RN #1 prepared Resident #B's PEG tube medications on 2/27/15 at 10:00 a.m., the following was observed: RN #1, without having used hand sanitizer or washing her hands prior to or between each medication, punched out each of the following tablet medications with her bare hands: escitalopram (antidepressant), furosemide (diuretic), and metoprolol tartrate (to treat high blood pressure). RN #1 placed each of the medications into a pouch with her bare hands and proceeded to crush all three medications in the pouch, then placed them in a medication cup for administration.</p> <p>Interview with the DON on 2/27/15 at 11:50 a.m., indicated the nurse should not have touched the tablets before crushing</p>			

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	<p>them. She should have used hand sanitizer before and after the resident's medication administration.</p> <p>A policy titled, " PREPARING ORAL TABLETS OR CAPSULES," was provided by the DON on 3/2/15 at 10:23 a.m. as current and indicated, "...General Guidelines: 12. Place the medication in the medication cup. If tablets or capsules are on a punch card, punch out into the cup...."</p> <p>3. During an observation of an insulin injection on 2/27/15 at 11:31 a.m., RN #2 entered Resident #22's room with the insulin syringe, cleaned the resident's left abdominal region, inserted the needle and pushed the plunger to administer the insulin. She then removed the needle, placed the safety cap on the syringe and threw the syringe away in the sharps container on the medication cart. During the injection of the insulin, RN #2 did not don gloves.</p> <p>Interview with RN #2 after the injection, indicated that she does not wear gloves when giving that resident injections. "He does not like the injections, so I had to get in and out fast."</p> <p>Interview with the DON on 2/27/15 at 11:50 a.m., the Nurse should have worn</p>			

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	<p>gloves to administer the insulin injection.</p> <p>4. During observation of Resident's #22 glucometer testing (testing of blood for blood sugars) on 2/27/15 at 11:18 a.m., RN #2 donned gloves, cleaned the resident's left thumb with an alcohol wipe, pricked the resident's finger with a lancet, placed a drop of blood into a test strip, received blood sugar reading, removed gloves with test strip with blood remaining in the gloves and threw the gloves away into the resident's garbage can and left the room.</p> <p>Interview on 2/27/15 with RN #2 at that time, indicated it was ok to throw away the test strip with blood in it in the resident's garbage can because the blood was contained within the test strip.</p> <p>Interview with the DON on 2/27/15 at 11:50 a.m., indicated the nurse should not have thrown the test strip with blood on it into the resident's trash can. It should have been placed in the sharps container on the medication cart.</p> <p>A policy titled, "Blood Sugar Testing," was provided by the DON on 3/2/15 at 10:23 a.m. was current and indicated, "...General Guidelines: 14. Lancet and test strip should be placed in the sharp container...."</p>			

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F 465 SS=E Bldg. 00	<p>5. During a room observation of Room 3 on 2/26/2015 at 10:37 a.m., a bath basin with a urinal inside was sitting on the bathroom floor uncovered and unlabeled next to the toilet.</p> <p>During the Environmental tour on 3/4/15 at 1:25 p.m. with the Administrator, Maintenance Supervisor and Environmental Supervisor, a bath basin with a urinal inside was sitting on the bathroom floor uncovered and unlabeled next to the toilet in the shared bathroom between Room 2 and Room 3. Three residents share this bathroom.</p> <p>At the time of the observation, the Administrator indicated the unlabeled, uncovered basin and urinal should not be stored on the floor and immediately directed staff to remove the items.</p> <p>3.1-18(a) 3.1-18(j) 3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional</p>	F 465	<b>F 465 The facility requests paper compliance for this citation. This Plan of</b>	03/30/2015			

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	<p>and safe environment related to marred and gouged walls, marred and gouged doors, cracked floor tile, cracked and stained sink counters, dirty toilet risers, and dirty toilet bowls on 3 of 3 units throughout the facility. (North Hall, West Hall and South Hall/ ACU Unit)</p> <p>Findings include:</p> <p>During an Environmental tour on 3/4/15 at 1:25 p.m. with the Administrator, Maintenance Supervisor, and Environmental Supervisor, the following was observed:</p> <p>1. West Hall</p> <p>a. In room 104, the bathroom tile was cracked at the base of the wall, the sink countertop had yellow stains, and the bottom of the bathroom door was gouged. One resident used this bathroom.</p> <p>b. The toilet riser had a brown substance on it in the bathroom in room 107. Two residents shared this bathroom.</p> <p>c. In the bathroom in room 112, the sink countertop was chipped, the cove base under the sink was peeling away, and the bathroom door was gouged. Two residents shared this bathroom.</p>		<p><i>Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p>a) <b>Room 104. Floor tile to be repaired by 3/20//15. Stains removed from sink on 3/6/15. Gouged door repaired on 3/6/15.</b></p> <p>b) <b>Room 107. Toilet riser cleaned immediately. Audits in place to ensure toilet risers are cleaned after each use.</b></p> <p>c) <b>Room 112. Countertop chip repaired on 3/6/15. Flooring estimate obtained on 3/16/15. Repairs to be completed by 4/3/15.</b></p> <p>d) <b>Room 115. Wall repair completed on 3/6/15.</b></p> <p>e) <b>Room 1 A &amp; 2B. Wall repairs completed on 3/6/15. Toilet bowl stains removed on 3/6/15. Door repair completed on 3/6/15. Floor tile to be repaired by 3/20/15.</b></p> <p>f) <b>Room 16. Door repair completed on 3/6/15.</b></p> <p>g) <b>Rooms 17 &amp; 18. Door repair completed on 3/6/15.</b></p> <p>h) <b>Room 19 &amp; 20. Flooring estimate obtained on 3/16/15. Repairs to</b></p>		

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	<p>d. The wall behind the recliner was gouged in room 115. One resident resided in this room.</p> <p>2. North Hall</p> <p>a. The wall behind the bed was marred and the toilet bowl had brown stains in room 1. One resident resided in this room.</p> <p>b. The outer door was marred and the floor tile was chipped in room 2. Two residents resided in this room.</p> <p>c. In room 16, the room door was gouged. Two residents resided in this room.</p> <p>3. South Hall/ ACU Unit</p> <p>a. The inner bathroom doors between rooms 17 &amp; 18 were gouged and marred. Three residents shared this bathroom.</p> <p>b. Room 19 had cracked floor tile by the closet, holes in the tile by the bathroom, and a marred outer room door. There were marred inner doors, a stained and buckled floor, and a dirty toilet riser in the bathroom shared with room 20. Two residents resided in this room and 4 residents shared this bathroom.</p> <p>c. The outer door for room 20 was</p>		<p><b>be completed by 4/3/15. Door repairs completed on 3/6/15. Toilet riser cleaned immediately. Audits in place to ensure toilet risers are cleaned after each use. i) Room 21. Door repairs completed on 3/6/15. 2) How the facility identified other residents: Audit will be completed of all resident rooms available for occupancy to identify any other environmental concerns. 3) Measures put into place/ System changes: Maintenance department will develop a schedule to complete inspection and repairs on at least 3 resident rooms per week until all rooms available for occupancy are completed. Schedule will then be implemented for inspection and repairs on all rooms available for occupancy at least semi-annually for routine maintenance and upkeep thereafter. Environmental Supervisor or Designee will perform rounds on assigned rooms at least 3x/week. Work orders will be written and submitted to maintenance for any issues requiring immediate attention. 4) How the corrective actions will be monitored: The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months,</b></p>		

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F 514 SS=D Bldg. 00	<p>gouged. Two residents resided in this room.</p> <p>d. The outer bathroom door for room 21 was marred. Two residents resided in this room.</p> <p>Interview with the Maintenance Supervisor and Environmental Supervisor at the time of the tour, indicated all of the areas were in need of cleaning and/or repair.</p> <p>3.1-19(f)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>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> <p>Based on record review and interview, the facility failed to ensure the Physician's Verbal Order for a medication was accurately documented. (Resident</p>	F 514	<p>then quarterly x1 for a total of 6 months. 5) Date of compliance: 3/30/15.</p> <p>F 514</p>	03/30/2015	

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	<p>#B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 3/2/15 at 8:27 a.m. Diagnoses included, but were not limited to, epilepsy, hemiplegia, and dysphagia (difficulty in swallowing).</p> <p>A Physician's Order dated 2/7/15, indicated " Phenobarbital (antiseizure medication) 32.4 mg (milligram) Give 0.5 tablet via PEG-tube (a tube used for administration of nutrition and medication that goes directly to the stomach) one time a day related to unspecified epilepsy until 2/13/15. "</p> <p>A Physician ' s Progress note dated 2/6/15 indicated "to the patient and family requested an attempt to decrease his seizure medication. Impression/Plan: 1. Seizure disorder decrease Phenobarbital by one half pill which is a 25% decrease, was discussed with the daughter, to re-evaluated in 1 to 2 weeks and if tolerated will continue to taper the dose, no need to follow levels as discontinuing."</p> <p>A Physician ' s Progress note dated 2/18/15 indicated "to continue on Phenobarbital dose reduction without any</p>		<p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Order was verified for accuracy</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>All new orders received in the last 30 days have been verified for accurate transcription.</b></p> <p><b>3) Measures put into place/ System</b></p>				

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	<p>seizures. A/P: 1. Seizure disorder continue Vimpat, Keppra, &amp; (and) Valporate Sodium (antiseizure medications) with dose reduction with Phenobarbital."</p> <p>Interview with the DON (Director of Nursing) on 3/2/15 at 2:35 p.m., indicted there was communication problem between the neurologist and the resident ' s Physician. The Phenobarbital was suppose to be decreased by a 1/2 tab each week instead of a "1/2 tab then discontinue." The resident ' s Physician was notified and the Phenobarbital dose was increased back to 32.4 mg, 1 tablet and will monitor for another decrease at a later time.</p> <p>Interview with the resident ' s Physician on 3/4/15 at 12:13 p.m., indicated, " The facility did not follow my orders correctly for the Phenobarbital reduction. It appears the nurse took my plan as an order. The reduction should have been a reduction of a half pill per week, then re-evaluate in 1-2 weeks.</p> <p>Phenobarbital('s) has a long half life, it stays in the person's system for days. The resident did not have any seizures and not off the medication for very long, that is why it was decided that labs were not necessary. He is to follow up with the neurologist for the rest of the reduction.</p>		<p><b>changes:</b></p> <p><b>Nurses were in-serviced on accurately receiving and transcribing new orders. New orders will be audited twice weekly on five random residents by DON or designee for accuracy and correct transcription.</b></p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance:</b></p> <p><b>3/30/2015</b></p>	

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R 000 Bldg. 00	<p>He is already on other anti-seizure medications as well. "</p> <p>3.1-50(a)(2)</p> <p>These deficiencies reflect state finding cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on March 11, 2015, by Janelyn Kulik, RN.</p>	R 000		
R 092 Bldg. 00	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire</p>			

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	<p>department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview the facility failed to invite the local fire department to participate in conducting a fire drill at least every 6 months.</p> <p>Finding includes:</p> <p>The fire drill records were reviewed on 3/3/15 at 3:30 p.m. The records lacked documentation to indicate the local fire department attended or was invited to any fire drills conducted from March 2014 through February 2015.</p> <p>During an interview with the Maintenance Supervisor on 3/4/15 at 8:30 a.m., he indicated he had probably called the fire department this past summer and left a message, but doesn't remember a response and has no documentation of the invitation.</p>	R 092	<p><b>R 092</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>A fire exit drill will be conducted at the facility on 3/19/15 including transmission of a fire alarm signal and simulation of emergency fire</b></p>	03/30/2015	

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			<p><b>conditions in conjunction with the local fire department.</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>All residents that reside in the Residential Section have the potential to be affected.</b></p> <p><b>3) Measures put into place/ System changes:</b></p> <p><b>Maintenance Director in-serviced regarding requirement to invite the local fire department to participate in conducting a fire drill at least every six months .</b></p> <p><b>An audit of fire drill documentation will be completed every six months to ensure local fire department is invited to participate.</b></p>		



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	<p>administration in a total sample of 5. (Resident #2)</p> <p>Finding includes:</p> <p>During an observation of the medication administration on 3/2/15 with LPN #1 at 9:23 a.m. for Resident #2, LPN #1 indicated the resident's "Pro-biotic" capsule punch card was empty and she could not administer the medication today. LPN #1 further indicated she would call the pharmacy to see if it had been re-ordered and then notify the Physician the medication had not been given.</p> <p>The punch card for the Pro-biotic had a red re-order sticker on the package (on what would have been the remaining last 2 pills in card).</p> <p>LPN #1 administered the rest of Resident #2 's medications and indicated to the resident that the Pro-biotic was missing. At that time, the resident verbalized she was upset and the medication should have been re-ordered in a timely manner. Resident #2 further indicated she "really needed that Pro-biotic."</p> <p>Interview with the DON (Director of Nursing) on 3/2/15 at 2:30 p.m., indicated the day shift nurse should have</p>		<p><b>compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Medication was reordered and received from pharmacy on the next scheduled delivery</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>Pharmacy will complete an audit to verify that all medications are present.</b></p>				

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R 298 Bldg. 00	<p>re-ordered the medication when 2 pills were left, as the red sticker indicated.</p> <p>Interview with LPN #1 on 3/2/15 at 3:15 p.m. indicated the pharmacy was contacted, the medication was not re-ordered previously and would be sent to the facility to arrive in the morning.</p> <p>The resident's record was reviewed on 3/2/15 at 10:00 a.m. Diagnoses included, but were not limited to, anxiety and traumatic amputation above the knee.</p> <p>A Physician's Order dated 1/30/15 indicated, Probotic Daily Capsule, give 1 capsule by mouth one time a day for prophylactic.</p> <p>A policy titled, "Refill Orders," was provided by the DON on 3/2/15 at 3:00 p.m. and deemed as current. The policy indicated, "Refill orders: 1. Reorder all medication two days in advance of need. Medications packed in bubble cards have a red 're-order' sticker on a bubble as a reminder that only a two-day supply remains in the card..."</p> <p>410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be</p>		<p><b>3) Measures put into place/ System changes:</b></p> <p><b>Pharmacy will complete an audit to ensure all medications are on hand. Nurses will be in-serviced on when to re-order medications. DON or designee will audit assisted living med cart once weekly to ensure all medications are present.</b></p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance:</b></p> <p><b>3/30/2015</b></p>	

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	<p>employed, or under contract, and shall:</p> <p>(A) be responsible for the duties as specified in 856 IAC 1-7;</p> <p>(B) review the drug handling and storage practices in the facility;</p> <p>(C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping;</p> <p>(D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and</p> <p>(E) review the drug regimen of each resident receiving these services at least once every sixty (60) days.</p> <p>Based on record review and interview, the facility failed to ensure a pharmacy drug regimen review was completed every sixty days for 4 of 5 residents reviewed for pharmaceutical services in a total sample of 5. (Resident's #2, #3, #4, and #5)</p> <p>Findings include:</p> <p>1. Record review for Resident #2 was completed on 3/4/15 at 10:28 a.m. The resident's diagnoses included, but were not limited to, anxiety, hypothyroidism and osteoporosis.</p> <p>Review of the Pharmacist Medication Regimen Review indicated the last pharmacy drug review for Resident #2 was completed on June 16, 2014.</p> <p>2. Record review for Resident #3 was</p>	R 298	<p><b>R 298</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	03/30/2015

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	<p>completed on 3/4/15 at 11:33 a.m. The resident's diagnoses included, but were not limited to, hypertension, depression, and bipolar disorder.</p> <p>Review of the Pharmacist Medication Regimen Review indicated the last pharmacy drug review for Resident #3 was completed on June 16, 2014.</p> <p>3. Record review for Resident #4 was completed on 3/4/15 at 12:46 p.m. The resident's diagnosis included, but were not limited to, hypertension and hyperlipidemia.</p> <p>Review of the Pharmacist Medication Regimen Review indicated the last pharmacy drug review for Resident #4 was completed on June 16, 2014.</p> <p>4. Record review for Resident #5 was completed on 3/4/15 at 12:58 p.m. The resident's diagnosis included, but were not limited to, hypertension, depression, and schizophrenia.</p> <p>Review of the Pharmacist Medication Regimen Review indicated the last pharmacy drug review for Resident #5 was completed on June 16, 2014.</p> <p>Interview with the Director of Nursing on 3/4/15 at 3:34 p.m., indicated she spoke</p>		<p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>Pharmacist medication review completed on all residents</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>Pharmacy audited all residents</b></p> <p><b>3) Measures put into place/ System changes:</b></p> <p><b>DON or designee will audit residents charts monthly for pharmacy medication review to ensure they are completed timely.</b></p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3 months, then quarterly x1 for a total of 6 months.</p>	

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R 301 Bldg. 00	<p>with the pharmacy and the pharmacy had not reviewed any of the above residents medications since June 2014. She further indicated the pharmacy had indicated this was a mistake on their part.</p> <p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, record review, and interview, the facility failed to ensure all medications were labeled properly according to current Physician's Orders for 1 of 5 residents reviewed for medication administration in a total sample of 5. (Resident #6)</p> <p>Finding includes:  During the observation of medication administration on 3/3/15 at 9:47 a.m.</p>	R 301	<p><b>5) Date of compliance:</b>  <b>3/30/2015</b></p> <p><b>R 301</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p>	03/30/2015

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	<p>with RN #1, Resident #6's Gas Relief medication label indicated 1 tablet by mouth every 6 hours as needed.</p> <p>The resident's record was reviewed on 3/3/15 at 10:15 a.m. Diagnoses included, but were not limited to, hypertension.</p> <p>Review of the Physician's Order dated 2/24/15 indicated, Simethicone Tablet 125 mg (milligram), give 1 tablet by mouth every 6 hours as needed for indigestion AND give 1 tablet by mouth two times a day for indigestion.</p> <p>The February 2015 MAR (Medication Administration Record) indicated the resident received Simethicone tablet 125 mg twice a day.</p> <p>Interview with RN #1 on 3/3/15 at 9:50 a.m., indicated the medicine was scheduled to be given twice daily in the computer on the MAR. "That's how the medicine came from the pharmacy, I guess I could write on the box that it is scheduled."</p> <p>Interview with the DON (Director of Nursing) on 3/3/15 at 10:40 a.m., indicated there should have been a change in direction sticker placed on the medication container.</p>		<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>1) Immediate actions taken for those residents identified:</b></p> <p><b>A change of direction sticker was affixed to the identified medication</b></p> <p><b>2) How the facility identified other residents:</b></p> <p><b>An audit was performed of all residents that have had a change in medication dosage in the last 30 days.</b></p> <p><b>3) Measures put into place/ System changes:</b></p> <p><b>Nurses were in-serviced on placing a change of direction sticker on the medication label when the dosage or directions change. Orders will be reviewed at least three times a</b></p>	

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	A policy titled, "Pharmore Drugs," was provided by the DON on 3/2/15 at 10:23 a.m. and was deemed as current. The policy indicated, "...LABEL DIRECTION CHANGES: 1. When the directions change on a medication, the pharmacy will not send a new label. Rather, the nurse receiving the directions change order should affix a 'Directions Changed-Refer to Chart' sticker to the bottom right hand corner of existing label...."		<p><b>week by DON or designee for dosage changes and medication card will be audited for change of direction sticker as indicated.</b></p> <p><b>4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly x3</p> <p>months, then quarterly x1 for a total of 6 months.</p> <p><b>5) Date of compliance:</b></p> <p><b>3/30/2015</b></p>	