STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 07/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD HOUSE	297 S 100 E WASHINGTON, IN 47501

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R000000	This visit was for a State Residential Licensure Survey. Survey dates: 07/08/13 and 07/09/13 Facility number: 004904 Provider number: NA AIM number: N/A Survey team: Dorothy Watts RN TC Martha Saull RN Census bed type: Residential: 31 Total: 31 Census payor type: Other: 31 Total: 31 Sample: 07 These state findings are cited in accordance with 410 IAC 16.2 Quality review completed by Jodi Meyer, RN, on July 12, 2013	R000000		

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

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

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R000295	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure schedule III and V controlled substances were maintained in a secure, double locked storage area for 1 of 1 rooms observed with controlled substances stored in the residents room. Findings include: On 7/8/13 at 3 P.M., Resident #1 was interviewed. She indicated she shares a room with her husband (Resident #2) and they have medication in a locked drawer in their bathroom. She indicated the locked drawer was located behind an unlocked door in a cabinet in the bathroom. At the time, an unlocked cabinet door was opened to reveal behind it, a drawer with a key type locking mechanism observed on the front of the drawer. At the time, the drawer was pulled on by the handle, and the drawer opened, 2 1/2 - 3 inches. There was observed to be a metal, tongue type mechanism (which was observed in a perpendicular	R000295	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. **Citation #1 R 295 410 IAC 16.2-5-6(a) Pharmaceutical Services- Noncompliance** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident #1's controlled medications were placed in a secured locked box, which was placed in a locking drawer in the apartment. The resident was re-educated to keep apartment door locked when not in apartment. **How the facility will identify other**	08/05/2013

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	position to the drawer) which came in contact with the drawer frame and caught at the top of the drawer. With minimal effort, the drawer was able to be entirely opened, exposing a zip lock bag of medications in pharmacy bottles. At the time, the drawer was closed by applying minimal pressure to the tongue type mechanism and pushed the door closed. On 7/8/13 at 3:05 P.M., the DON (Director of Nursing) was interviewed. She indicated the resident usually tells the staff when she takes any of the locked medications, which were stored in the bathroom. The DON indicated the resident's daughter brought in the medications from home and placed them in the cabinet with the lock on the drawer, in the bathroom. The DON indicated only the residents (husband and wife) in the room and the daughter had a key to the drawer which contained the medications. At the time, the DON was made aware of the drawer which contained the medications in the resident's room, not being secured. She indicated she would have the maintenance man fix it right away. The DON indicated she checked the medications monthly in the resident's room to make sure the drawer only contains medications which they have		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Residents who self-administer medications were audited to ensure proper, secured storage of controlled substances. Residents found to have unsecured controlled substances will have their medications placed in a secure locked box, which will be placed in a locking drawer in the apartment. Residents who self- administer their medications will be re-educated to lock their apartment doors when not present in apartment. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure regarding Medication Management. The Wellness Director and/or Designee will be responsible for ensuring that controlled substances are secured for those residents who self-administer their medications per our policy and procedure to ensure compliance with R 295 410 IAC 16.2-5-6(a). **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or	

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	a physician's order for to be kept at the bedside. On 7/9/13 at 7:45 A.M., Resident #1 and #2 were observed sitting in the dining room. At 7:46 A.M. LPN #1 was observed to open the unlocked entry door of the resident's room. At the time, LPN #1 was interviewed and she indicated the resident's usually locked their door when they are out of the room. LPN#1 went to the bathroom and opened the cabinet door, which contained the locked drawer with the medications. At the time, the drawer was opened 2 1/2 - 3 inches, again being caught with the metal tongue mechanism but was again easily opened entirely with minimal pull to the drawer. LPN #1 indicated at the time, the drawer was not locked and/or secure. On 7/9/13 at 9:40 A.M. a current copy of the current facility policy and procedure for Medication Management was received from the DON. The policy and procedure was dated January 2013. The policy and procedure included, but was not limited to, the following: "Medications kept in a resident's apartment must not be accessible to others. Thus, if the resident wishes to store the medications in an unsecured area in		Designee will perform random weekly audits of residents that self-administer controlled substances to ensure continued compliance for a period of 6 months. Findings will be reviewed through the Emerald House QA process after 6 six months to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. **By what date will the systemic changes be completed?** August 5, 2013	

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	the apartment, the door of the apartment must be locked at all times when the resident is not present. If the resident does not consistently keep the door locked, a locking drawer, cabinet or box should be used...If the resident stores controlled drugs in his/her apartment, the controlled drugs must be kept in a locking box (to which staff does not have a key) AND (sic) the apartment door or keyed cabinet must be kept locked on the Resident's Negotiated Service Plan the agreed-upon procedures to ensure the security of medications stored in a resident's apartment. (e.g. "John (name included in policy) agrees to store medications in his locking kitchen drawer and/or will lock the apartment door when leaving for meals, etc.)." On 7/9/13 at 11:20 A.M., the DON was again interviewed. She provided the following: copies of Resident #1 and #2 "Folstein Mini Mental Status Examination," dated 4/13/13 which had a total score for each residents of 30. The form indicated a score of 24 or above is considered normal; Review Log for Self Administration of Medications for each resident was dated 5/30/13 and 6/25/13. These forms indicated Resident #1 and #2 continued to self medicate			

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	independently and with assistance as outlined in the NSP (negotiated service plan); the DON indicated the she had reviewed the drawer in the resident's room and it included the following medications: Resident #1: Lorazepam (benzodiazepine) 0.5 mg, 83 tablets Lortab (opioid analgesic) 5/325 mg 30 tablets Percocet (opioid analgesic) 5 mg, 25 tablets. Resident #2: Lortab (opioid analgesic) 5/325 mg, 53 tablets			