

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/16/2015
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NAME OF PROVIDER OR SUPPLIER  CROWNPOINTE OF GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 831 SWOPE STREET GREENFIELD, IN 46140
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R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00181776 and IN00181781.</p> <p>Complaint IN00181781 - Substantiated. State deficiencies related to the allegations are cited at R0241, R0243, R0304 and R0354.</p> <p>Complaint IN00181776 - Substantiated. State deficiencies related to the allegations are cited at R0026, R0241, R0243, R0304 and R0354.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: October 15 and 16, 2015</p> <p>Facility number: 012798 Provider number: 012798 AIM number: N/A</p> <p>Census bed type: Residential: 47 Total: 47</p> <p>Census payor type: Medicaid: 24 Other: 23 Total: 47</p> <p>Sample: 4</p>	R 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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R 0026 Bldg. 00	<p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 30576 on October 21, 2015.</p> <p>410 IAC 16.2-5-1.2(a) Residents' Rights - Noncompliance (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands.</p> <p>Based on interview and record review the facility failed to provide resident rights upon admission for 1 of 4 resident's reviewed for resident rights (Resident</p>	R 0026	Resident "B" is no longer a resident of this Facility. For all other residents that could have been affected by this practice, the Administrator will have a meeting	11/24/2015			

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R 0241 Bldg. 00	<p>#B).</p> <p>Findings include:</p> <p>Review of the record of Resident #B on 10/15/15 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, depression, anxiety, chronic pain, chronic airway obstruction and hypertension.</p> <p>The record of Resident #B did not have documentation that the resident received resident rights upon admission.</p> <p>Interview with the Director Of Nursing (DON) on 10/15/15 at 11:25 a.m., indicated the facility was unsure when Resident #B was admitted to the facility, but it was in August 2015. The DON indicated the resident was believed to have stayed at the facility for 4 days and then was discharged to another facility. The DON indicated she was not employed at the facility when Resident #B was a resident. The DON indicated Resident #B did not have resident rights acknowledgement signed in her record.</p> <p>This residential tag relates to complaint IN00181776.</p>				<p>with all residents and give them a new copy of their resident's rights and each resident will sign a document stating in writing that they received a copy of their Resident's Rights. This document will be placed in the residents chart. Prior to admission each resident shall be given a copy of Resident's Rights and shall signify in writing by signing the resident rights acknowledgement. Document will be placed in resident chart. Should residents rights be updated or changed Administrator/Designee will re-educate residents, have resident's sign an acknowledgement and file acknowledgement in resident's charts. Director of Health Services/Designee will do random audits of 5 resident charts, quarterly or until compliance is evident, to insure every resident has a copy of their Resident Rights and signed documentation is in chart.</p>		
	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and						

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	<p>the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, interview and record review the facility failed to have physician orders for Resident #B while she resided at the facility and failed to administer exelon patches (medication to treat dementia) as ordered by the physician for Resident #A for 2 of 4 residents reviewed for medications (Resident #B and Resident #A).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #B on 10/15/15 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, depression, anxiety, chronic pain, chronic airway obstruction and hypertension.</p> <p>Resident #B had a blank physician order for medications in her record.</p> <p>The record of Resident #B indicated on 8/4/15 at 4:08 p.m., there were 10 prescriptions (RX) delivered to the facility for Resident #B from pharmacy #1. The delivery form indicated RX numbers for the medications and not the</p>	R 0241	Resident"B" is no longer a resident of this facility. For all other residents who could have been affected by this practice, all current resident charts will be audited to insure all charts have Physician's orders for treatment and/or medications. For resident "A" All nursing staff have been inserviced on Documentation and proper application of "patches" including Exelon patches. Nursing staff were instructed to always date and initial all patches and document on MAR sheet. All MAR's other than those residents who self-administer their own medications, will have their Medication Administration Records placed in a binder for use by each Qualified Medication Aide when completing medication pass/treatment. Any resident having signed Physician's orders for any type of patch or PRN medication will have separate MAR designated for that medication/treatment. QMA's will apply Exelon patches per Physician's order, date and initial of individual administering treatment. Director of Health Services/Designee will audit 5 resident's Medication Administration Records per week	11/24/2015

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	<p>prescription name of the medication that were delivered.</p> <p>The "services rendered" note for Resident #B, dated 8/4/15 (no time), indicated medications were picked up for Resident #B at pharmacy #2 and the resident's fentanyl patches (pain medication) were put in the "communication room". The note did not indicate what other medications were picked up from pharmacy #2.</p> <p>The "medication return sheet" for Resident #B dated 8/7/15 (no time), indicated 148 oxycodone (pain medicine) 10 milligram (mg) tablets were returned to the pharmacy #1.</p> <p>Interview with the Director Of Nursing (DON) on 10/15/15 at 11:25 a.m., indicated Resident #B did not have physician orders for medications or a Medication Administration Record (MAR). The DON indicated the procedure for new admission residents was, the facility would receive a list of the medications the resident was prescribed and fax the medication list to residents Medical Doctor to be signed. The DON indicated the procedure was not followed for Resident #B. The DON indicated the exact dates the resident resided at the facility were unknown, but</p>		for 2 months or until compliance is evident, to insure all are receiving treatment/medications as ordered by Physician.				

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	<p>it was August 2015 and the resident was at the facility for four days.</p> <p>Interview with the Executive Director (E.D.) on 10/16/15 at 11:15 a.m., indicated the previous E.D. made an allegation on 8/6/15 as she was leaving the building that Resident #B had medications missing. The E.D. indicated it was alleged the resident had 9 fentanyl patches missing and 35 oxycodone tablets missing. The E.D. indicated the resident did not have any physician orders to verify if any medication were missing.</p> <p>Interview with the Pharmacist from pharmacy #1 on 10/16/15 at 12:30 p.m., indicated the pharmacy had sent Resident #B 180 oxycodone 10 mg tablets to the facility. The Pharmacist indicated all 180 oxycodone 10 mg were returned to the pharmacy on 8/6/15.</p> <p>The facility "Admission Documentation" policy provided by the Executive Director (E.D.) on 10/16/15 at 2:50 p.m., indicated the "Things needed before admission" included, but were not limited to, "current list of medication orders, signed by the doctor."2. Resident #A's record was reviewed on 10/15/15 at 11:20 a.m. Her diagnoses documented on her most recent Physician Order Sheet</p>			

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	<p>dated 8/3/15, indicated but were not limited to, Alzheimer's and dementia. The Physician Order Sheet dated 8/3/15, and initiated 7/1/14, indicated she would receive an exelon 13.3 milligram (mg) patch daily for a diagnosis of Alzheimer's disease.</p> <p>Resident #A's Evaluation of Needs/Service Plan dated as reviewed by the facility on 6/10/15, indicated she had impaired decision making skills and required supervision. She was unable to take medications unless they were administered by someone else.</p> <p>An interview with Resident #A's daughter-in-law on 10/15/15 at 10:45 a.m., indicated Resident #A's medications were stored in a cabinet in Resident #A's room. The facility dispensed Resident #A medications because Resident #A was unable to dispense her own medications. Resident #A's daughter-in-law counted Resident #A's exelon patches on 9/1/15, and there were 95 patches in the cabinet. She spoke with the Executive Director (ED) that day and the ED informed her she would take care of it. Resident #A's daughter-in-law notified the pharmacy 3 days later and had the exelon patch delivery to the facility placed on hold until December 2015, so Resident #A could use up the exelon patches she</p>						

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	<p>already had.</p> <p>On 10/15/15 at 12:45 p.m., an observation was made with the DON of the medications stored in Resident #A's cabinet in her room. Resident #A's September and October 2015, Medication Administration Report was stored in the cabinet with her medications. No exelon 13.3 mg patch was listed as a medication for Resident #A on her September and October 2015, Medication Administration Record. Resident #A had an unopened box containing 30-13.5mg exelon patches with a fill date of 1/16/15, an unopened box containing 30-13.5 mg exelon patches with a fill date of 5/8/15, an open box containing 12-13.3 mg exelon patches with a fill date of 7/31/15, an open box containing 15-13.3 mg exelon patches with a fill date of 8/28/15. The total amount of unused 13.3 mg exelon patches equaled 87 patches. The DON indicated the exelon patch should be listed on Resident #A's Medication Administration Report because they were received from the pharmacy. She believed the exelon patch order may not have been listed on Resident #A's Medication Administration Report because Resident #A's family had placed the medication on hold because there were so many unused patches in Resident #A's cabinet.</p>			

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R 0243 Bldg. 00	<p>The Medication Administration policy and procedure provided by the DON on 10/15/15 at 11:50 a.m., indicated "Policy: Residents of the facility receive medications as ordered by their physician to treat specific medical conditions... If a resident does not meet the criteria for independent administration of the medication(s), medication administration will be executed by a licensed nurse or a qualified medication aide. Procedure:...</p> <p>7). Should the resident be incapable to self-administer medications with or without reminders, a licensed nurse or qualified medication aide shall be expected to administer medications as ordered by the physician and document the same..."</p> <p>This Residential tag relates to Complaint IN00181776 and IN00181781.</p> <p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review the</p>	R 0243	Resident "B" is no longer a resident of this facility For all	11/24/2015
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	<p>facility failed to document medications administered to residents on a medication and treatment record for 4 of 4 residents reviewed for medication administration (Resident #B, Resident #D, Resident #A and Resident #C).</p> <p>Findings include:</p> <p>1.) Review of the record of Resident #B on 10/15/15 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, depression, anxiety, chronic pain, chronic airway obstruction and hypertension.</p> <p>Resident #B's record indicated there were no documentation on a Medication Administration Record (MAR) that indicated what medication, dosage, time or the person administering the medication to the resident.</p> <p>The "services rendered" note for Resident #B, dated 8/5/15 (no time) indicated the resident pulled her call light for pain medication. The staff explained to the resident she had received all her medication for the night until 7:00 a.m. the next day.</p> <p>Interview with the Director Of Nursing (DON) on 10/15/15 at 11:25 a.m., indicated Resident #B did not have a</p>		<p>other resident who could have been affected by this practice, all QMA's have been in-serviced on Documentation. The individual administering the medication will document in the resident's MAR that indicate, time, dosage, name of medication or treatment, and the initials of the person administering the medications, all MAR's for residents that do not administer their own medications will be placed in a binder that QMA's will take with them when doing medication pass to ensure prompt and accurate documenting. Director of Health Services/Designee will do random audits of 5 resident Medication Administration Records monthly for 3 months, or until compliance is evident, to ensure QMA's are documenting in the residents Medication Administration Record and initials are in the space provided for each medication or treatment administered</p>				

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	<p>MAR for the medications she received while she resided in the facility.</p> <p>2.) Review of the record of Resident #D on 10/15/15 at 2:55 p.m., indicated the resident's diagnoses included, but were not limited to, hypertension, spinal fracture, anxiety, depression and dementia.</p> <p>The physician orders for Resident #D, dated 9/1/15 (no time), indicated the resident was ordered Tylenol #3 (pain medication with codeine) two tablets four times a day for pain. The order indicated the Tylenol #3's original prescription date was 3/11/14.</p> <p>The MAR for Resident #D, dated 8/8/15 to 9/4/15, indicated 70 times the Tylenol #3's were not signed as given to the resident.</p> <p>Interview with the DON on 10/15/15 at 10:40 a.m., indicated Resident #D had Tylenol #3 missing, but it was unsure how many because the there was not a narcotic count sheet for August 2015. The DON indicated the facility implemented a narcotic sign out sheet on 9/1/15.</p> <p>Interview with the Executive Director (E.D.) on 10/16/15 at 11:15 a.m.,</p>			

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	<p>indicated Resident #D's family called the facility on 8/31/15 and reported the resident did not receive her Tylenol #3 that morning. The E.D. indicated as far as she could tell there was only one dose of the Tylenol #3's missing as the facility had implemented the narcotic sign out sheet until 9/1/15. 3. Resident #A's record was reviewed on 10/15/15 at 11:20 a.m. Her diagnoses documented on her most recent Physician Order Sheet dated 8/3/15, indicated but were not limited to, Alzheimer's disease, dementia, arthritis, hypothyroidism, hypertension, depression, and vitamin deficiency. The Physician Order Sheet indicated she would be provided the following medications: Exelon 13.3 milligrams (mg) patch daily. Namenda 10 mg tablet 2 times a day. Multivitamin tablet daily. Vitamin E 1000 unit capsule daily. Glucosamine 500 mg tablet daily. Fish Oil EC 1000 mg softgel daily.</p> <p>A physician's order for Resident #A dated 10/13/15 at 10:30 a.m., indicated Resident #A would start Macrobid 1 tablet every 12 hours times 7 days.</p> <p>Resident #A's Evaluation of Needs/Service Plan dated as reviewed by the facility on 6/10/15, indicated she had impaired decision making skills and required supervision. She was unable to</p>			

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	<p>take medications unless they were administered by someone else.</p> <p>On 10/15/15 at 12:45 p.m., an observation was made with the DON of the medications stored in Resident #A's cabinet in her room. Resident #A's September and October 2015, Medication Administration Report was stored in the cabinet with her medications. Resident #A had 87 exelon 13.3 mg patches in her cabinet. No exelon 13.3 mg patch was listed as a medication she received on Resident #A's September and October 2015 Medication Administration Report. Resident #A had a bottle of Macrobid 100 mg capsules with a fill date of 10/13/15. No Macrobid 100 mg capsule was listed as a medication she received on her October 2015 Medication Administration Report. Resident #A had a bottle of Zofran 4 mg tablets with a fill date of 9/12/15, that had not been listed as a medication she received on her September or October 2015, Medication Administration Report. The instructions on the bottle of Zofran 4 mg indicated Resident #A could receive up to 1 tablet 3 times a day as needed (PRN). The DON indicated the exelon patch should be listed on Resident #A's Medication Administration Report because they were received from the pharmacy. She believed the exelon patch may not have</p>			

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	<p>been listed on Resident #A's Medication Administration Report because Resident #A's family had placed the medication on hold because there were so many unused patches in Resident #A's cabinet. The DON indicated pharmacy had not sent a Medication Administration Report for the Macrobid Resident #A had started on 10/13/15. She believed the pharmacy had not sent a Medication Administration Report for the Macrobid because it was a short term medication. She indicated pharmacy did not list resident's PRN medications on their Medication Administration Report and that was why the Zofran 4 mg tablet was not included on the Report. No information was documented on Resident #A's October 2015, Medication Administration Report she had received the following medications: Namenda XR 28 mg capsule at bedtime on 10/13/15. Multivitamin tablet in the morning on 10/10/15, 10/11/15, 10/12/15, 10/13/15, 10/14/15, and 10/15/15. Vitamin E 1,000 unit tablet at bedtime on 10/13/15. Glucosamine 500 mg capsule in the morning on 10/12/15, 10/13/15, and 10/14/15. Fish Oil EC 1,000 mg softgel at bedtime on 10/13/15. Cranberry tablet at bedtime on 10/9/15, and 10/13/15. The DON indicated she was unsure why the medications had not been documented as given to Resident #A and</p>			

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NAME OF PROVIDER OR SUPPLIER  CROWNPOINTE OF GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 831 SWOPE STREET GREENFIELD, IN 46140
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	<p>there was no explanation on Resident #A's Medication Administration Report.</p> <p>4. Resident #C's record was reviewed on 10/16/15 at 10:45 a.m. His diagnoses documented on his most recent Physician Order Sheet dated 9/22/15, indicated but were not limited to, diabetes type II, gastroesophageal reflux disease, depression, neuropathy, hyperlipidemia, seizures, constipation, hypertension, chronic pain, aphasia, and cerebral vascular accident. The Physician Order Sheet indicated Resident #C would be provided the following medications: Oxycodone-APAP 5-325 mg tablet 3 times a day PRN. Baclofen 10 mg tablet daily. Levetiracetam 500 mg tablet daily. Omeprazole 20 mg capsule daily. Simvastatin 20 mg tablet daily. Divalproex 375 mg tablet at bedtime. Cymbalta 60 mg tablet 2 times a day. Lisinopril 10 mg tablet daily. Gabapentin 300 mg tablet 4 times a day. Gabapentin 600 mg tablet 4 times a day. Naproxen 500 mg 2 times a day.</p> <p>Resident #C's Evaluation of Needs/Service Plan dated as reviewed by the facility on 6/10/15, indicated he had impaired decision making skills and required supervision. He was unable to take medications unless they were administered by someone else.</p>			

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	<p>No Oxycodone-APAP 5-325 mg tablet was listed as a medication Resident #C received on his Medication Administration Report for September 30th to October 27th. Resident #C's Medication Administration Report for September 30th to October 27th 2015, indicated the following medications were not documented as given: Baclofen 10 mg tablet on the morning of 10/1/15 and 10/2/15, and at bedtime 10/13/15. Lisinopril 10 mg tablet the morning of 10/1/15 and 10/15/15. Simvastatin 20 mg tablet at bedtime 10/15/15. Divalproex 250 mg tablet on 10/10/15 and 10/13/15. Gabapentin 600 mg tablet in the morning on 10/1/15 and 10/15/15. Gabapentin 600 mg tablet at noon on 10/1/15, 10/7/15, and 10/15/15. Gabapentin 600 mg tablet in the evening on 10/13/15 and at bedtime on 10/13/15. Gabapentin 300 mg capsule in the morning on 10/1/15 and 10/15/15. Gabapentin 300 mg capsule at noon on 10/1/15, 10/5/15, and 10/15/15. Gabapentin 300 mg capsule in the evening on 10/13/15 and at bedtime 10/13/15. Levetiracetam 500 mg tablet in the morning on 10/1/15 and 10/15/15 and at bedtime on 10/9/15 and 10/13/15. Duloxetine 60 mg capsule in the morning on 10/1/15, 10/2/15, and 10/15/15, and at bedtime 10/13/15. Naproxen 500 mg</p>			

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	<p>tablet in the morning on 10/1/15 and 10/15/15, and at bedtime 10/13/15. Divalproex 125 mg tablet at bedtime on 10/3/15, 10/4/15, 10/9/15, and 10/13/15. Omeprazole 20 mg capsule in the morning on 10/1/15, 10/12/15, 10/13/15, 10/14/15, and 10/15/15.</p> <p>On 10/16/15 at 10:00 a.m., the ED indicated she had initiated a controlled substance sign off sheet 9/1/15.</p> <p>On 10/16/15 at 11:15 am., the DON provided a Controlled Drug Report for Resident #C that indicated he had received Oxycodone PRN since 9/27/15. The DON indicated she was unable to provide any documentation Resident #C had received any Oxycodone PRN prior to 9/27/15.</p> <p>The Medication Administration policy and procedure provided by the DON on 10/15/15 at 11:50 a.m., indicated "Policy: Residents of the facility receive medications as ordered by their physician to treat specific medical conditions... If a resident does not meet the criteria for independent administration of the medication(s), medication administration will be executed by a licensed nurse or a qualified medication aide. Procedure:... 7). Should the resident be incapable to self-administer medications with or</p>			

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R 0304 Bldg. 00	<p>without reminders, a licensed nurse or qualified medication aide shall be expected to administer medications as ordered by the physician and document the same..."</p> <p>This Residential tag relates to Complaint IN00181776 and IN00181781.</p> <p>410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit.</p> <p>Based on observation and interview, the facility failed to store a resident's medications in a locked area for 1 of 4 resident's reviewed for medications. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 10/15/15 at 11:20 a.m. Her diagnoses documented on her most recent Physician Order Sheet dated 8/3/15, indicated but were not limited to, Alzheimer's and dementia.</p>	R 0304	Resident "B" is no longer a resident of this facility. For resident "A" this resident has agreed to have all her medications, other than schedule two medications, locked in a lockbox in her apartment. QMA's will administer all her medications and document this on her Medication Administration Record, with initials in space provided. All Schedule two drugs for residents who have signed Physicians orders for this medication, will be locked behind triple lock in the Nursing office, in a sturdy locked file cabinet, in a locked Narcotics box. Only the Nurse and QMA's will have	11/24/2015

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	<p>Resident #A's Evaluation of Needs/Service Plan dated as reviewed by the facility on 6/10/15, indicated she had impaired decision making skills and required supervision. She was unable to take medications unless they were administered by someone else.</p> <p>An interview with Resident #A's daughter-in-law on 10/15/15 at 10:45 a.m., indicated Resident #A's medications were stored in a cabinet in Resident #A's room. The facility dispensed Resident #A medications because Resident #A was unable to dispense her own medications.</p> <p>On 10/15/15 at 12:45 p.m., an observation was made with the DON of the medications stored in Resident #A's cabinet in her room. There were exelon patches in 4 different boxes lying loose in her cabinet. There was a bottle of Macrobid and a bottle of Zofran in a metal box in the cabinet, along with other miscellaneous medications in packets. Resident #A's door was unlocked to her room and there was no lock on Resident #A's cabinet door or metal box that contained medications. The DON indicated Resident #A forgot to lock her room door sometimes.</p> <p>On 10/16/15 at 1:00 p.m., the Administrator indicated according to the</p>		<p>access to these medications. Exelon patches for this resident and any other residents who could have been affected by this practice, will have date and initials of individual placing the patch. This will be documented on a separate MAR designated just for this treatment. The Director of Health Services/Designee will do random audits of 5 residents Medication Administration Records who have signed physician orders for a patch/treatment, for 3 months or until compliance is evident, to ensure QMA's are documenting placing the patch, dating and initialing by individual administering the treatment.</p>				

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R 0354 Bldg. 00	<p>move-in- agreement, a resident may choose not to have their medications locked up in their room, but if they choose that, they have to agree to keep their room door locked.</p> <p>This Residential tag relates to Complaint IN00181776 and IN00181781.</p> <p>410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis.</p> <p>Based on interview and record review the facility failed to document upon discharge a list of medications or treatments the resident was receiving at the time of discharge for 1 of 4 resident's reviewed for medication administration (Resident #B).</p>	R 0354	Resident "B" is no longer a resident of this facility. For all other residents who could have been affected by this practice, all residents being transferred from the facility will have a transfer/discharge form completed. Transfer form will include: Identification data, name of transferring institution, name of	11/24/2015			

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	<p>Finding include:</p> <p>1.) Review of the record of Resident #B on 10/15/15 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, depression, anxiety, chronic pain, chronic airway obstruction and hypertension.</p> <p>Interview with the Director Of Nursing on 10/15/15 at 11:25 a.m., indicated the exact dates Resident #B resided at the facility were unknown, but it was August 2015 and the resident was at the facility for four days.</p> <p>The nursing note for Resident #B, dated 8/5/15 at 11:00 a.m., indicated the resident was being discharged from the facility to another facility due to the facility was unable to meet the resident's needs. The documentation did not indicate any medications the resident was prescribed or what medications were sent with the resident at the time of discharge.</p> <p>Interview with the DON and Administrator on 10/16/15 at 10:39 a.m., indicated Resident #B did not have a transfer form. The Administrator and DON indicated neither had worked at the facility while Resident #B resided in the facility.</p>		<p>receiving institution and date of transfer , resident's personal property when transferred to an acute care facility, Nurses notes, relating to residents functional abilities and physical limitations, nursing care, medications, treatment, current diet order and condition on transfer, diagnosis, date of chest x-ray and skin test for tuberculosis.</p> <p>Administrator/Designee will do random audit of 1 resident chart monthly for 3 months, or until compliance is evident, that Transfer/Discharge forms are being completed for all residents being transferred.</p>	

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R 0408  Bldg. 00	<p>This Residential tag relates to Complaint IN00181781 and Complaint IN00181781.</p> <p>410 IAC 16.2-5-12(c) Infection Control - Noncompliance (c) Each resident shall have a diagnostic chest x-ray completed no more than six (6) months prior to admission. Based on interview and record review the facility failed to have an updated chest x-ray for a new admission prior to the resident's admission for 1 of 4 residents for medication administration (Resident #B).</p> <p>Finding include:</p> <p>1.) Review of the record of Resident #B on 10/15/15 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, depression, anxiety, chronic pain, chronic airway obstruction and hypertension.</p> <p>Interview with the Director Of Nursing (DON) on 10/15/15 at 11:25 a.m., indicated the exact dates Resident #B resided at the facility were unknown, but it was August 2015 and the resident was at the facility for four days. The DON indicated the resident did not have a current chest x-ray prior to her admission.</p> <p>The "policy: Move in health Screen,</p>	R 0408	Resident "B" is no longer a resident of this facility. For all other residents who could have been affected by this practice, all current resident charts will be audited by Director of Health Services/ QMA's to ensure every resident has a current Chest x-ray in their chart. The facility move-in checklist for new admissions, ( which has 8 different procedures that must be completed prior to admission) states, updated chest x-ray completed no more than 6 months prior to admission is #1 on the list. The Administrator/Designee will audit all new admission charts, to ensure all residents have all 8 documents on the facility move-in checklist, which includes the updated chest x-ray.	11/24/2015

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R 0410 Bldg. 00	<p>Chest X-ray and T.B. test" in Resident B's record, the signature of the resident or responsible party was blank, the document was, dated 7/31/15, and was signed by the facilities previous Executive Director. The document indicated "Each resident must have a diagnostic chest x-ray completed no more than six (6) months prior to admission."</p> <p>Interview with the DON on 10/16/15 at 10:00 a.m., indicated Resident #B's last chest X-ray the facility had documented was dated 5/4/14.</p> <p>410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p>			

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	<p>Based on interview and record review the facility failed to administer a tuberculin skin test (test done to indicate if there had been any exposure to tuberculosis) prior to the resident's admission or upon the resident's admission for 1 of 4 residents reviewed for medication administration (Resident #B).</p> <p>Finding include:</p> <p>1.) Review of the record of Resident #B on 10/15/15 at 10:30 a.m., indicated the resident's diagnoses included, but were not limited to, congestive heart failure, depression, anxiety, chronic pain, chronic airway obstruction and hypertension.</p> <p>Interview with the Director Of Nursing (DON) on 10/15/15 at 11:25 a.m., indicated the exact dates Resident #B resided at the facility were unknown, but it was in August 2015 and the resident was at the facility for four days. The DON indicated the resident did not have a tuberculin skin test prior to admission or on admission to the facility.</p> <p>The "policy: Move in health Screen, Chest X-ray and T.B. test" in Resident B's record the signature of the resident or responsible party was blank, the document was, dated 7/31/15, and was signed by the facilities previous</p>	R 0410	Resident "B" is no longer a resident of this facility. For all other residents who could have been affected by this practice, all current residents charts will be audited by Director of Health Services/QMA's to ensure every resident has a current skin test for tuberculosis in their chart. The facility move-in checklist for new admissions (which has 8 different procedures that must be completed prior to admission) states, #6, Documentation of TB test done within the last 3 months or TB test (1st and 2nd step) done before admission. The Administrator/Designee will audit all new admission charts prior to admission, to ensure resident has all 8 documents on the facility move-in checklist, including the skin test for tuberculosis.	11/24/2015			

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	<p>Executive Director. The document indicated "Unless there is documented history of a positive tuberculin skin test, each resident must have a mantoux (TB test) within 3 months prior to or upon admission to the facility."</p> <p>The "Tuberculin Testing" document in Resident #B's record, dated 7/31/15 (no time) was blank. The document indicated "The test must be read 48-72 hours after the injection."</p>				