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| 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 01/22/2016 |
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| NAME OF PROVIDER OR SUPPLIER VERMILLION PLACE | STREET ADDRESS, CITY, STATE, ZIP CODE 449 MAIN ST ANDERSON, IN 46016 |
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| R 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaints #IN00190704 and #IN00190946.</p> <p>Complaint #IN00190704 - Substantiated. State deficiencies related to the allegations are cited at R0241.</p> <p>Complaint #IN00190946 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey Dates: January 21 and 22, 2016</p> <p>Facility Number: 011970 Provider Number: 011970 AIM number: N/A</p> <p>Residential Census: 37</p> <p>Sample: 6</p> <p>This state finding is cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on January 25, 2016.</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 0241 Bldg. 00 | <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(e) The administration of medications and 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 record review and interview, the facility failed to ensure medications were administered by licensed nursing personnel or qualified medication aides. This deficient practice had the potential to effect 32 residents who received medication on the second shift of the 37 residents living in the facility.</p> <p>Findings include:</p> <p>The clinical record for Resident E was reviewed on 1/22/16 at 10:21 a.m. Diagnoses included, but were not limited to pancreatic mass, hypertension, neuropathy, hiatal hernia, osteoporosis and spinal stenosis.</p> <p>Review of the Medication Administration Record (MAR) for January 2016 indicated Resident E received the following medications on the evening shifts on January 6th and 7th: Coreg (antihypertensive) 6.25 mg at 5:00 p.m., Zocor (anti-hypercholesterol) 10 mg at</p> | R 0241 | <p>R000 Preparationand/or execution of this Plan of Correction in general or any corrective actionset forth herein, in particular, does not constitute an admission or agreementby Vermillion Place of the facts alleged or the conclusions set forth in thestatement of deficiencies The Plan of Correction and the specificcorrective actions are prepared and/or executed solely because of provisions ofstate laws. Vermillion Place desires this Plan of Correction to be consideredthe facility's Allegation of Compliance. Compliance is effectiveFebruary 6, 2016. Thisbuilding respectfully requests consideration for paper compliance from the Planof Correction. R241 1The alleged deficient practice had the potential to effect 32Residents who received medication on the second shift These residentswere identified There was no resident negatively affect by the passing</p> | 02/06/2016 |

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| | <p>5:00 p.m. The medications were initialed as given by a nursing student. The record lacked any documentation of the supervision of the nursing student.</p> <p>The clinical record for Resident F was reviewed on 1/22/16 at 12:00 p.m. Diagnoses included, but were not limited to, depression, hypertension, diabetes type 2 and coronary atherosclerosis.</p> <p>Review of the MAR for January 2016 indicated Resident F received the following medications on the evening shifts on January 6th and 7th: Norvasc (antihypertensive) 5 mg at bedtime, Lipitor 40 mg at bedtime, Urecholine (urinary stimulant) 10 mg at 5:00 p.m., Wellbutrin XL (antidepressant) 300 mg at 8:00 p.m., Coreg (antihypertensive) 25 mg at 5:00 p.m., Catapres (antihypertensive) 0.1 mg (antilipemic) at 8:00 p.m., Apresoline (antihypertensive) 100 mg at 5:00 p.m. and Miralax (for constipation) 17 gm at bedtime. The medications were initialed as given by a nursing student. The record lacked any documentation of the supervision of the nursing student.</p> <p>The clinical record for Resident G was reviewed on 1/22/16 at 11:48 a.m. Diagnoses included, but were not limited to, carpel tunnel syndrome, vertigo,</p> | | <p>of medications by a nursing student Facility policy has been updated effective January 25, 2016 to reflect that no nursing students will pass any medications Only licensed nurses or QMA's will be allowed to pass any medication</p> <p>2 All residents medication sheets were reviewed for January 6 & 7, 2016. No other residents were affected.</p> <p>3 Facility policy regarding the passing of medications has been updated on January 25, 2016, to reflect that no nursing student may pass medications. Only licensed nurses or QMA's will be allowed to pass medication.</p> <p>4 Facility policy has been updated effective January 26, 2016 to reflect that no nursing students will pass any medications Only licensed nurses or QMA's will be allowed to pass any medication The Director of Nursing or their designee, and the Administrator, or their designee will monitor this</p> | | | | |

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| | <p>colonic diverticulosis, edema, fibromyalgia and restless leg syndrome.</p> <p>Review of the MAR for January 2016 indicated Resident G received the following medications on the evening shifts of January 6th and 7th: Calcitonin spray (calcium supplement) at 8:00 p.m., Hydrocodone (analgesic) 10-325 mg at 6:00 p.m., Lyrica (anticonvulsant) 75 mg at 5:00 p.m., Metoprol (antihypertensive) 25 mg at 5:00 p.m., Mirapex (antiparkinsons) 2 mg at bedtime, Restasis (eye drops) 0.05% at 5:00 p.m., Requip (antiparkinsons) 1 mg at bedtime, Savella ya(anti fibromyalgia) 50 mg at 5:00 p.m. and Ultram (analgesic) 50 mg at 4:00 p.m. and bedtime. The medications were initialed as given by a nursing student. The record lacked any documentation of the supervision of the nursing student.</p> <p>During an interview on 1/22/1 at 11:27 a.m., the Director of Nursing (DON) indicated on January 6 and 7, 2016 she had approved for an nursing student to administer medication to all the residents in the facility during the second shift. "I thought as long as the nursing student completed the pharmacology class with a "C" or better, they were allowed to administer medications under the supervision of a nurse or QMA (Qualified</p> | | | | | | |

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| | <p>Medication Aide). After I found out this was not the case, I immediately stopped him from administering medications. I called the Board of Health and they told me he had to take the 90 hour practicum for QMAs to be able to pass medications. He is in the process of enrolling in a program." The DON indicated the nursing student had administered medications to 32 residents who were scheduled to receive medications on the second shift during the January 6-7, 2016 time period. The DON indicated she was now aware that supervising the administration of medications was not within the QMA's scope of practice.</p> <p>During an interview on 1/22/16 at 11:33 a.m., QMA #3 indicated she had supervised the nursing student while he administered medications to the residents on the second shift on January 6 and 7, 2016. "I watched him give the medications to all of the residents. The only thing he did not give was insulin because our DON comes in and gives the insulin." QMA #3 indicated she did not document in the record she had supervised the medication administration.</p> <p>Review of a current undated policy titled "Q.M.A. [sic] Scope of Practice" was provided by the DON on 1/22/16 at 11:24 a.m. The policy indicated the following:</p> | | | |

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| | "...II. For a nursing student to function as an Q.M.A. [sic] they must be currently enrolled in a nursing program and have completed Fundamentals of Nursing and Pharmacology with a passing grade of C. Recently graduated nursing students (within last 2 years) can test out and function as a QMA." | | | | | | |