

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/18/2012
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NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031
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F0000	<p>This visit was for the Investigation of Complaint IN00101514.</p> <p>Complaint IN00101514 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F333 and F431.</p> <p>Survey dates: January 17 and 18, 2012.</p> <p>Facility number: 000420 Provider number: 155730 AIM number: 100266230</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 96 Residential: 11 Total: 107</p> <p>Census payor type: Medicare: 14 Medicaid: 65 Other: 28 Total: 107</p> <p>Sample: 3 Supplemental sample: 2</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F0000	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and we will continue to provide quality of care to all residents.	

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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F0282 SS=D	<p>Quality review completed on January 20, 2012 by Bev Faulkner, RN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a physician's order to resume Plavix (an antiplatelet medication) was resumed as ordered, resulting in a resident not receiving the medication for seven (7) days. This deficient practice affected 1 of 3 residents reviewed for proper administration of Plavix in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 1-17-12 at 3:05 p.m. His diagnoses included, but were not limited to diabetes, high blood pressure, coronary artery disease (CAD or heart problems), osteoarthritis, history of deep vein thrombosis (blood clots), depression and agitation.</p> <p>Review of the physician's orders indicated a telephone order, dated 12-1-11 at 11:00 a.m., that indicated to hold the Plavix 75</p>	F0282	<p>F282 Services by qualified persons/per care plan</p> <p>1.What corrective action will be accomplished: Prevention of medication errors</p> <p>2. How other Residents have the potential to be affected: All residents have the potential</p> <p>3.What measures will be put in place to prevent reoccurrence: Paper MAR to be used as a back up to the electronic MAR. Both are to be checked when administering medications. Review with QA team at least quarterly changes as needed.</p> <p>4. How the corrective action will be monitored: DON/ADON will check daily for 2 weeks then weekly for 6 weeks then monthly.</p> <p>5. By what date the changes will be completed: Feb. 01, 2012</p>	02/01/2012	

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	<p>milligrams (mg) beginning on 12-6-11 due to skin graft surgery to both eyes, scheduled for 12-16-11. Another telephone order, dated 12-6-11 at 4:30 p.m., indicated to resume the Plavix 75 mg one tablet daily by mouth for the resident's diagnosis of CAD.</p> <p>Review of the nurse's notes indicated a note, dated 12-6-11 at 10:45 a.m., that indicated a phone call from a family member of Resident #A was received which indicated the surgery scheduled for 12-16-11 had been canceled. Another nurse's note, dated 12-6-11 at 4:30 p.m., indicated the physician had been into the facility and ordered for the Plavix to be restarted.</p> <p>A nurse's note, dated 12-14-11 with no time noted, indicated, "Res[ident] has [symbol for not] rec'd [received] Plavix 75 mg since 12-7-11 d/t [due to] was on hold for upcoming surgery which was canceled for 12-6-11. [Physician's name] N.O. [had given new order] to resume Plavix 75 mg on 12-6-11." The nurse's note indicated the pharmacy and physician had been notified of this error.</p> <p>Review of the EMAR indicated the physician-ordered Plavix 75 mg one tablet daily by mouth, was administered on December 1, 2, 3, 4, and 5, 2011. It</p>				

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	<p>indicated this medication was held on December 6, 2011 as ordered. It indicated it was not administered December 7, 8, 9, 10, 11, 12, and 13, 2011. It indicated it was administered daily beginning on December 14, 2011.</p> <p>In interview with RN #1 on 1-17-12 at 3:18 p.m., she indicated the Plavix was put on hold in the EMAR (electronic medication administration record) for surgery on 12-16-11, beginning 12-6-11. She indicated on 12-6-11 the family canceled the surgery. She indicated the new order to resume the Plavix was received on 12-6-11 and the pharmacy was notified of this on the same date. She indicated the resume order for the Plavix "did not show on the EMAR." She indicated the problem [not receiving the Plavix from 12-6-11 through 12-13-11] was identified on 12-14-11. She indicated the physician and the family were notified of the error on the same date the error was identified. She indicated the physician did not issue any new or change orders at that time.</p> <p>In interview with the Director of Nursing (DON) on 1-18-12 at 9:28 a.m., she indicated a Medication Error form had been completed and was awaiting the signature of the physician.</p>				

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F0333 SS=D	<p>This Federal tag relates to Complaint IN00101514.</p> <p>3.1-35(g)(2)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a potential significant medication error did not occur related to the failure to ensure a physician's order to resume Plavix (an antiplatelet medication) was resumed as ordered, resulting in a resident not receiving the medication for seven (7) days. This deficient practice affected 1 of 3 residents reviewed for proper administration of Plavix in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 1-17-12 at 3:05 p.m. His diagnoses included, but were not limited to diabetes, high blood pressure, coronary artery disease (CAD or heart problems), osteoarthritis, history of deep vein thrombosis (blood clots), depression and agitation.</p> <p>Review of the physician's orders indicated</p>	F0333	<p>F333 Residents free of significant med errors</p> <p>1.What corrective action will be accomplished: Prevention of medication errors</p> <p>2.How other Residents have the potential to be affected: All residents have the potential</p> <p>3.What measures will be put in place to prevent reoccurrence: Paper MAR to be used as a back up to the electronic MAR. Both are to be checked when administering medications.</p> <p>4.How the corrective action will be monitored: DON/ADON will check daily for 2 weeks then weekly for 6 weeks then monthly. Review with Q.A. team at least quarterly and changes as needed.</p> <p>5. By what date the changes will be completed: Feb. 01, 2012</p>	02/01/2012	

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	<p>a telephone order, dated 12-1-11 at 11:00 a.m., that indicated to hold the Plavix 75 milligrams (mg) beginning on 12-6-11 due to skin graft surgery to both eyes, scheduled for 12-16-11. Another telephone order, dated 12-6-11 at 4:30 p.m., indicated to resume the Plavix 75 mg one tablet daily by mouth for the resident's diagnosis of CAD.</p> <p>Review of the nurse's notes indicated a note, dated 12-6-11 at 10:45 a.m., that indicated a phone call from a family member of Resident #A was received which indicated the surgery scheduled for 12-16-11 had been canceled. Another nurse's note, dated 12-6-11 at 4:30 p.m., indicated the physician had been into the facility and ordered for the Plavix to be restarted.</p> <p>A nurse's note, dated 12-14-11 with no time noted, indicated, "Res[ident] has [symbol for not] rec'd [received] Plavix 75 mg since 12-7-11 d/t [due to] was on hold for upcoming surgery which was canceled for 12-6-11. [Physician's name] N.O. [had given new order] to resume Plavix 75 mg on 12-6-11." The nurse's note indicated the pharmacy and physician had been notified of this error.</p> <p>A nurse's note, dated 12-15-11 at 9:00 a.m., indicated the electronic medical</p>			

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	<p>administration record (EMAR) "did not show" the resumed order for Plavix 75 mg. The note indicated the computer company representative had been contacted to and was able to get the medication to show up on the EMAR as administered.</p> <p>Review of the EMAR indicated the physician-ordered Plavix 75 mg one tablet daily by mouth, was administered on December 1, 2, 3, 4, and 5, 2011. It indicated this medication was held on December 6, 2011 as ordered. It indicated it was not administered December 7, 8, 9, 10, 11, 12, and 13, 2011. It indicated it was administered daily beginning on December 14, 2011.</p> <p>In interview with RN #1 on 1-17-12 at 3:18 p.m., she indicated the Plavix was put on hold in the EMAR for surgery on 12-16-11, beginning 12-6-11. She indicated on 12-6-11 the family canceled the surgery. She indicated the new order to resume the Plavix was received on 12-6-11 and the pharmacy was notified of this on the same date. She indicated the resume order for the Plavix "did not show on the EMAR." She indicated the problem [not receiving the Plavix from 12-6-11 through 12-13-11] was identified on 12-14-11. She indicated the physician and the family were notified of the error</p>			

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	<p>on the same date the error was identified. She indicated the physician did not issue any new or change orders at that time.</p> <p>In interview with the Director of Nursing (DON) on 1-18-12 at 9:28 a.m., she indicated a Medication Error form had been completed and was awaiting the signature of the physician. She indicated the EMAR record is confusing for a medication placed on hold. She indicated she had difficulty reading the EMAR as it appeared to her that the Plavix had not been given since December 1, 2011. She indicated she had spoken to the pharmacy in regard to this issue and was awaiting a response from them. She indicated on the EMAR that if a medication is placed on hold, it simply does not appear on the EMAR. She indicated that one "can go into the system to check the actual order. That's just not very efficient to have to pull each resident's chart to verify every single medication order. The computer system is suppose to make it easier." In interview with the DON on 1-18-12 at 11:37 a.m., she indicated she had been able to access the discontinued medications on the computer system and it indicated the Plavix had been administered as ordered on December 1 through 5, 2011.</p> <p>This Federal tag relates to Complaint</p>				

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F0431 SS=D	<p>IN00101514.</p> <p>3.1-48(c)(2)</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 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</p>	F0431	F431 Drug records, label/store drugs and biologicals 1.What corrective action will be	02/01/2012	

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	<p>over the counter medications (OTC's) were properly labeled for 8 medications belonging to 3 total residents, 1 of 3 residents in a sample of 3 and for 2 of 2 residents in a supplemental sample for proper labeling of medications. (Residents #C, #D, and #E.)</p> <p>Findings include:</p> <p>A. During a medication pass observation on 1-17-12 between 4:20 p.m. and 4:55 p.m. with RN #1, a random observation was conducted of the medication cart. Review of OTC's indicated the following medications for Resident #D did not have the physician's name on the medication bottle: Viactiv, Aspirin 81 milligrams (mg), Centrum Vitamins, Docusate 50 mg/Senna, and Osteo Biflex.</p> <p>RN #1 was observed to add the physician's name to the above bottles on 1-17-12 at 4:57 p.m.</p> <p>B. During a medication pass observation on 1-17-12 between 4:20 p.m. and 4:55 p.m. with RN #1, a random observation was conducted of the medication cart. Review of OTC's indicated the following medication for Resident #E did not have the physician's name on the medication bottle: Benefiber.</p>		<p>accomplished:</p> <p>OTC medications will be correctly labeled per regulation requirements.</p> <p>2. How other Residents have the potential to be affected: All residents have the potential</p> <p>3. What measures will be put in place to prevent reoccurrence: Policy has been changed to include M.D. name on the label. Review with QA team at least quarterly changes as needed.</p> <p>4. How the corrective action will be monitored: DON/ADON will check medication carts weekly for 4 weeks then monthly.</p> <p>5. By what date the changes will be completed: Feb. 01, 2012</p>		

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	<p>RN #1 was observed to add the physician's name to the above bottles on 1-17-12 at 4:57 p.m.</p> <p>C. During a medication pass observation on 1-18-12 between 8:07 a.m. and 8:42 a.m. with LPN #2, a random observation was conducted of the medication cart. Review of OTC's indicated the following medication for Resident #C did not have the physician's name on the medication bottles: Vitamin C 500 mg and Zinc 50 mg.</p> <p>In interview with LPN #2 on 1-18-12 at 8:42 a.m., she indicated she was unaware of the need for the physician's name on the label of the OTC medication.</p> <p>The Director of Nursing (DON) provided a copy of a policy entitled, "Over the Counter Medication Labels," on 1-18-12 at 9:20 a.m. with an "updated" date of 11-7-11. This policy indicated "Label must include: Res[ident] Name and medication ordered directions. Do not: cover expiration date or medication name on bottle." This policy, dated 11-7-11, did not indicate to identify the physician's name on the medication.</p> <p>The DON provided a revised copy of the above "Over the Counter Medication Labels," on 1-18-12 at 11:37 a.m., with an</p>				

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	<p>"updated" date of 1-18-12 This policy indicated "Over the counter medications must be identified with the following:</p> <ol style="list-style-type: none"> <li>1. Resident Name</li> <li>2. Physician Name</li> <li>3. Expiration Date</li> <li>4. Name of Drug</li> <li>5. Strength</li> </ol> <p>Do not: cover expiration date or medication name on bottle."</p> <p>This Federal tag relates to Complaint IN00101514.</p> <p>3.1-25(l)(2)</p>				