

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 11/24/2015
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NAME OF PROVIDER OR SUPPLIER APERION ESTATES PERU, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 KITTYHAWK DRIVE PERU, IN 46970
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00185221.</p> <p>Complaint IN00185221 - Substantiated. State deficiencies related to the allegations are cited at R241, R242, R243 and R349.</p> <p>Survey dates: November 23 and 24, 2015</p> <p>Facility number: 013327 Provider number: 013327 AIM number: N/A</p> <p>Residential census: 28</p> <p>Sample: 7</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed by 14454 on December 2, 2015.</p>	R 0000		
R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and</p>			

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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	<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 record review and interview, the facility failed to ensure 1 of 7 residents reviewed, received medications as ordered by the physician. (Resident B)</p> <p>Finding includes:</p> <p>On 11/24/15 at 9:10 A.M., a review of the clinical record for Resident B was conducted. The record indicated Resident B was admitted on 5/5/15. The diagnoses included, but were not limited to: hypertension, type 2 diabetes mellitus, anxiety, constipation, gastro-esophageal reflux disease and retrograde amnesia.</p> <p>A Medication Administration Record (MAR), dated 10/1/15 - 10/31/15, indicated the following medications were not administered as ordered (documented with a circle around initials of the nurse) from 10/1/15 thru 10/21/15: famotidine 20 mg. (milligrams) by mouth BID (twice a day) for esophageal reflux, linzess 290 mg. by mouth daily for constipation and aricept 10 mg. by mouth daily for memory loss. In addition, the MAR</p>	R 0241	<p>R 241 The facility requests paper compliance for this citation. <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 provision of federal and state law. 1) Immediate actions taken for those residents identified: Resident #B An abdominal assessment was completed, the physician was notified and orders were received to discontinue the Lactulose solution and the dulcolax caps. 2) How the facility identified other resident: Medication supply and administration records were reviewed for all residents receiving medication administered by the facility to ensure medications are available and given as ordered 3) Measures put into place/systems changes: Licensed staff were re-educated on Medication Administration,</i></p>	12/18/2015

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	<p>indicated the following medication were not administer, as ordered (documented with a circle around initials of the nurse), from 10/1/15 thru 10/31/15: lactulose solution 30 ml (milliliters) by mouth daily for constipation and dulcolax delayed release 5 mg. by mouth TID (three times a day) every Monday, Wednesday and Friday for constipation.</p> <p>A MAR dated, 11/1/15 - 11/30/15, indicated the following medications were not administrated as ordered (documented with a circle around initials of the nurse) from 11/1/15 thru 11/24/15: lactulose solution 30 ml (milliliters) by mouth daily for constipation and dulcolax delayed release 5 mg. by mouth TID (three times a day) every Monday, Wednesday and Friday for constipation.</p> <p>There was no explanation on the MAR to indicated why the medications had not been given as ordered, by the physician.</p> <p>A review of the nursing notes did not indicate the resident had been assessed for signs or symptoms of constipation, increased problems's with memory or reflux. There were no bowel movements documented in the clinical chart.</p> <p>A post-it note, undated, in the clinical record indicated mail order pharmacy</p>		<p>medication availability and documentation. For residents that the facility administers medications to, the licensed staff will notify the family or responsible party of medications needing refills when there is approximately one week supply remaining. If medications are not available, the medication will be circled and a progress note will be entered describing the steps taken to obtain the medications, as well as physician and family notification. 4) How the corrective actions will be monitored: The Director of Nursing or Designee will audit medication supply and medication administration records for omissions and documentation on at least 3 residents per week receiving medications administered by the nurse. The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months. 5) Date of compliance: 12/18/15</p>				

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	<p>name with a fax number for new orders or for renew orders. The post-it note further indicated the resident's member number.</p> <p>During an interview, on 11/24/15 at 9:50 A.M., the DON (Director of Nursing) indicated she had circled her initials on the MAR, to indicate the medications were not administered to the resident on those dates, as medication was not available. The DON indicated the resident's contact person was responsible to obtain the resident's medications from the pharmacy. The DON further indicated she had not contacted the physician or the resident's contact person, nor had the facility attempted to obtain the medications from a pharmacy. The DON indicated she had not tried the the mail order pharmacy number to inquire about the resident's renewal orders as she did not write the note in the chart.</p> <p>During an interview, on 11/24/15 at 10:30 A.M., Resident B indicated she could not recall when she last had a bowel movement.</p> <p>During an interview, on 11/24/15 at 10:50 A.M., the DON indicated she had no documentation of bowel movements or assessments for Resident B in regard to signs or symptoms of constipation.</p>				

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	<p>On 11/24/15 at 9:40 A.M., the Administrator provided a policy titled "Pharmaceutical Services," dated 4/2015, and indicated the policy was the one currently used by the facility. The policy indicated "...8. Resident's may use the pharmacy of their choice for medications administered by the facility, as long as the pharmacy: a. Complies with the facility policy for receiving, packaging, and labeling of pharmaceutical products unless contrary to state and federal laws. b. Provides prescribed services on a prompt and timely manner c. Refills prescription drugs when needed, in order to prevent interruption of drug regimens...."</p> <p>On 11/24/15 at 11:35 A.M., the Administrator provided the policy titled "Preparing Oral Tablets or Capsules," dated August 2012, and indicated the policy was the one currently used by the facility. The policy indicated "...17. Document each medication given. If the medication was refused or omitted, record this fact on the appropriate record, and document the reason...."</p> <p>This State tag relates to Complaint IN00185221.</p>			

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R 0242 Bldg. 00	<p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on record review and interviews, the facility failed assess and document the effects of a new medications prescribed for acute dermatitis (rash) during the duration of the medications administration for 1 of 7 residents reviewed. (Resident B)</p> <p>Finding includes:</p> <p>During an interview, on 11/23/15 at 7:45 P.M., CNA #1 indicated the Resident B was taken to a local emergency room (ER) by her family on 10/21/15, and returned to facility sometime between 8:00 p.m. or 8:30 p.m. The CNA indicated he contacted the Administrator and the Director of Nursing (DON) regarding medications for the resident after being seen in the ER. He was instructed to put the medications in a locked drawer. CNA #1 further indicated a nurse did not come into the facility during his shift, which ended at 10:00 P.M. CNA #1 indicated CNA #2 followed him.</p>	R 0242	<p>R 242</p> <p>The facility requests paper compliance for this citation.</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 provision of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #B No further complaints or visible signs of skin irritation or rash noted.</p> <p>2) How the facility identified</p>	12/18/2015			

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	<p>During an interview, on 11/23/15 at 11:05 P.M., CNA#2 indicated she worked the night shift and had never seen the DON come in to see a resident or give a medication.</p> <p>On 11/24/15 at 9:10 A.M., a review of the clinical record for Resident B was conducted. The Resident B's diagnoses included, but were not limited to: hypertension, type 2 diabetes mellitus, anxiety, constipation, gastro-esophageal reflux disease and retrograde amnesia.</p> <p>The Discharge Orders from a local emergency room, dated 10/21/15, indicated the resident had dermatitis, an inflammation of the skin, which appeared as a rash on the resident's skin. The resident was prescribed benadryl and a medrol dose pack.</p> <p>A verbal physician's ordered, dated 10/21/15, indicated the resident was ordered diphenhydramine (benadryl - an antihistamine) 25 mg (milligrams) by mouth every 6 hours as needed for itching/rash for 10 days, and Medrol (a corticosteroid) 4 mg. tablets with the following directions: give 6 tablets by mouth one time a day for one day (10/22/15), give 1 tablet by mouth TID (three times a day) for 1 day before</p>		<p>other resident:</p> <p>All residents receiving assistance with medication administration have the potential to be affected.</p> <p>3) Measures put into place/systems changes:</p> <p>Licensed staff were re-educated on Medication Administration, new medication monitoring, assessment and documentation. Documentation and assessment of change in condition and/or new medications initiated will be documentated daily for 3 days.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing or Designee will audit medication administration records and corresponding progress notes per week to ensure documentation of assessment was completed for any residents receiving new medication orders or change in condition.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months.</p>				

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	<p>breakfast, after lunch, after supper (10/23/15), give 2 tablets by mouth at bedtime for 1 day (10/23/15), give 1 tablet by mouth QID (4 times a day) for 1 day before breakfast, after lunch, after supper and at bedtime (10/24/15), give 1 tablet TID before breakfast, after lunch, after supper for one day (10/25/15), give 1 tablet by mouth BID (twice a day) for 1 day before breakfast and at bedtime (10/26/15), and give 1 tablet one time a day by mouth before breakfast (10/27/15).</p> <p>The Medication Administration Record (MAR), dated 10/22/15, indicated the resident received Benadryl 25 mg. by mouth every 6 hours, as needed for itching/rash on 10/22/15, 10/23/15 and 10/24/15 twice a day. The medrol dose pack was given as ordered from 10/22/15 thru 10/27/15.</p> <p>A nursing note, dated 10/22/15 at 7:00 A.M., indicated "...resident complaint of itching continued late into evening. family was notified and took resident to ER for evaluation. returned with new orders for Medrol dose pak, and Benadryl 25 mg every 6 hours PRN [as needed] for itching. notified residents PCP [physician] of ER visit and orders approved...." There were no other nursing notes after the 10/22/15 entry.</p>		<p>5) Date of compliance: 12/18/15</p>				

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R 0243 Bldg. 00	<p>During an interview, on 11/24/15 at 9:50 A.M., the Director of Nursing (DON) indicated she had not assessed the resident for a rash or itching before or after giving the PRN benadryl. She further indicated she did not assess the resident for use of the medrol during the 5 day administration of the medication.</p> <p>A policy regarding PRN medication administration and assessment documentation was requested on 11/24/15; however, a policy was never received.</p> <p>This State tag relates to Complaint IN00185221.</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 record review and interviews, the facility failed to ensure there was</p>	R 0243	R 243 The facility requests paper compliance for this	12/18/2015			

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	<p>thorough documentation regarding when the medication was administered as needed for 3 of 7 residents reviewed. (Resident B, F and H)</p> <p>Findings include:</p> <p>1. A list of resident's for whom the facility administered medications, provided by the Administrator on 11/23/15 at 8:30 P.M. included Resident F's name.</p> <p>The clinical record for Resident F was reviewed on 11/24/15 at 10:30 A.M. The current Medication Administration Record (MAR) for November 2015 indicated the facility's only licensed nurse, had administered Hydrocodone-Acetaminophen (pain medication) tablets three to four times a day from November 1 - 23, 2015. The resident's pain level on a scale of 1 - 10 was recorded on the record. There was no indication of when the medication was administered. Nursing notes for November 2015 were reviewed and although the resident's routine use of pain medications on an as needed basis were mentioned, there was no documentation on when each pain medication had been administered.</p>		<p>citation. <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 provision of federal and state law. 1) Immediate actions taken for those residents identified:</i> Resident #F, #H, #B- Unable to correct incomplete documentation. 2) How the facility identified other resident: The medication administration records for residents receiving assistance with medication administration have been reviewed for appropriate documentation of PRN medications 3) Measures put into place/systems changes: All licensed staff were re-educated on PRN Medication Administration and documentation. The licensed staff will assess the resident with a complaint outside their normal condition status. PRN medications will be administered per physicians orders and outcomes documented. 4) How the corrective actions will be monitored: The Director of Nursing or Designee will audit medication administration records</p>				

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	<p>2. A list of resident's for whom the facility administered medications, provided by the Administrator on 11/23/15 at 8:30 P.M., included Resident H's name.</p> <p>The clinical record for Resident H was reviewed on 11/24/15 at 11:00 A.M. The current MAR for November 2015 for Resident H indicated the nurse had administered the as needed anti-inflammatory pain medication, Naproxen 220 mg tablets twice a day every day from November 1 - 23. There was no time the medication was administered documented on the MAR. The November 2015 nursing progress notes did not contain any specific documentation of the twice daily administration of the pain medication.</p> <p>During an interview, on 11/24/15 at 12:00 P.M., the DON (Director of Nursing) indicated although she was aware of generally expected protocol for administering as needed medications, she was not sure why she had not documented the information when she had administered the requested pain medications. She indicated she had thought assisted living did not require as much documentation.</p>		<p>and corresponding documentation of assessment and PRN medication/outcomes of at least 3 residents per week that receive medication administration assistance. The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance: 12/18/15</p>				

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	<p>3. On 11/24/15 at 9:10 A.M., a review of the clinical record for Resident B was conducted. The record indicated the resident was admitted on 5/5/15. The resident's diagnoses included, but were not limited to: hypertension, type 2 diabetes mellitus, anxiety, constipation, gastro-esophageal reflux disease and retrograde amnesia.</p> <p>The Discharge Orders from a local emergency room, dated 10/21/15, indicated Resident B had dermatitis, an inflammation of the skin, which appeared as a rash on the resident's skin. The resident was prescribed benadryl and a medrol dose pack.</p> <p>A verbal physician's ordered, dated 10/21/15, indicated the resident was ordered diphenhydramine (benadryl - an antihistamine) 25 mg (milligrams) by mouth every 6 hours PRN (as needed) for itching/rash for 10 days.</p> <p>A Medication Administration Record (MAR), indicated the resident received the benadryl 25 mg twice a day on 10/22/15, 10/23/15 and 10/24/1. The Director of Nursing (DON) documented her initials on the MAR, indicating she administered the medication to the resident. There was no documented time of the administration of the medication.</p>			

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R 0349 Bldg. 00	<p>During an interview, on 11/24/15 at 10:50 A.M., the DON indicated she had documented on the MAR, she had administered the PRN medication benadryl but had not documented the time the medication was given.</p> <p>A policy, regarding PRN medication administration and documentation was requested on 11/24/15; however, a policy was never received.</p> <p>This State tag relates to Complaint IN00185221.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure verbal physician orders were signed by the physician timely for 4 of 7 residents. (Residents B, D, E and F)</p>	R 0349	R 349 The facility requests paper compliance for this citation.	12/18/2015

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>The clinical records for Resident D, E, F, and H were reviewed on 11/24/15 between 9:30 A.M. - 11:00 A.M. and indicated the following:</p> <ol style="list-style-type: none"> The physician orders for Resident E for September and October 2015 were not signed by the physician. The most recently signed physician orders were signed in July 2015. The physician orders for Resident D for October 2015 were not signed. The most recent signed physician orders were signed in September 2015. The physician orders for Resident F were signed in for May 2015 and a medication order change for two medications, written in September 2015 were signed by the physician however the rest of the resident's orders had not been signed by a physician. On 11/24/15 at 9:10 A.M., a review of the clinical record for Resident B was conducted. The record indicated the resident was admitted on 5/5/15. The resident's diagnoses included, but were not limited to: hypertension, type 2 diabetes mellitus, anxiety, constipation, 		<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 provision of federal and state law.</i></p> <p>1) Immediate actions taken for those residents identified:</p> <p>Resident #E September and October orders signed and current.</p> <p>Resident #D September and October orders signed and current.</p> <p>Resident #F June, July, August, September & October physician orders are signed and current.</p> <p>Resident #B July, August & September physician orders are signed and current.</p> <p>2) How the facility identified other resident:</p>	

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	<p>gastro-esophageal reflux disease and retrograde amnesia.</p> <p>A Medication Review Report dated 5/31/15 - 6/30/15 indicated a physician had reviewed and approved the orders for Resident B by signing his name and dating the form on 6/1/15. The chart contained no other reviewed and signed orders by a physician to date. The electronic verbal medication orders did not indicate a physician had reviewed or signed a printed physician orders form for the months of July, August, September, or October of 2015</p> <p>On 11/24/15 at 12:35 P.M., the Administrator provided a policy titled "Protocol for Physician Orders," undated, and indicated the policy was the one currently used by the facility. The policy indicated "...1. When a nurse receives an order by phone or verbal order, it will be documented as such on the order electronically. 2. The date the order was received will be printed on the consolidated order form. Consolidated order report will be printed for signature every 60 days. 3. The physician will sign and date the consolidated order form for all of the telephone orders that were received during the 60 day period...."</p> <p>This State tag relates to Complaint</p>		<p>An audit of physician orders will be completed to identify other residents affected.</p> <p>3) Measures put into place/systems changes:</p> <p>The Director of Nursing was re-educated on the protocol for printing consolidated orders for physician signature every 60 days per policy.</p> <p>The Director of Nurses will print a consolidated order report for each resident to be signed every 60 days.</p> <p>4) How the corrective actions will be monitored:</p> <p>The Director of Nursing will audit at least 10 resident charts monthly to ensure consolidated physician orders are signed at least every 60 days.</p> <p>The results of these audits will be reviewed in Quality Assurance Meeting monthly until 100% compliance is achieved x3 consecutive months.</p> <p>5) Date of compliance:</p> <p>12/18/15</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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