

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 06/30/2014
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NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING APARTMENTS	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
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R000000	<p>This visit was for the a State Residential Licensure Survey. This visit included the investigation of Complaint #IN00150323.</p> <p>Complaint #IN00150323 - Substantiated. State residential deficiencies related to the allegations are cited at R0045.</p> <p>Survey date: June 26, 27 and 30, 2014.</p> <p>Facility Number: 004168 Provider Number: 004168 AIM Number: N/A</p> <p>Survey team: Julie Wagoner, RN, TC Lora Swanson, RN Sharon Ewing, RN (06/26/14) Debora Kammeyer (06/26/14 and 06/27/14)</p> <p>Census bed type: Residential: 51 Total: 51</p> <p>Census payor type: Other: 51 Total: 51</p> <p>Sample: 07</p> <p>These state findings are cited in</p>	R000000	Please see all responses, including the complaint finding in R0045.	
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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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R000026	<p>accordance with 410 IAC 16.2-5.</p> <p>Quality Review completed on July 9, 2014, by Brenda Meredith, R.N.</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 record review and interviews, the facility failed to ensure 1 of 7 clinical records reviewed contained a signed acknowledgement of resident rights. (Resident H)</p>	R000026	<p>1. (R 026) Need for resident signed acknowledgement of receiving Residents' Rights a. After surveyor team exit, a facility review of the Resident #H's file determined that the required signed acknowledgement had</p>	07/01/2014			

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R000045	<p>Findings include:</p> <p>1. The closed clinical record for Resident #H was reviewed on 06/30/14. Resident #H was admitted to the facility, on 09/29/10, with diagnosis, including but not limited to hypothyroidism, hypertension, osteoporosis, hypercholesterolemia, arthritis, and removal of vertebra of the cervical spine. The resident was discharged from the facility on 05/12/14.</p> <p>There was no signed acknowledgement of a notification of resident rights located in the closed clinical record. Interview with CNA #15, on 06/30/14 at 3:00 P.M., indicated there was no resident rights documentation in the clinical record.</p> <p>410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the</p>		<p>been done and was filed appropriately (Attachment A). b. No deficient practice occurred. c. No changes are needed to ensure ongoing compliance. d. Routine audits of residents' files will continue to ensure needed documentation is present.</p>	

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	<p>resident ' s clinical record and transmit a copy to the following:</p> <ul style="list-style-type: none"> (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). <p>(B) Record the reasons in the resident ' s clinical record.</p> <p>(C) Include in the notice the items described in subdivision (9).</p> <p>(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged.</p> <p>(8) Notice may be made as soon as practicable before transfer or discharge when:</p> <ul style="list-style-type: none"> (A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or 			

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	<p>(E) a resident has not resided in the facility for thirty (30) days.</p> <p>(9) For health facilities, the written notice specified in subdivision (7) must include the following:</p> <p>(A) The reason for transfer or discharge.</p> <p>(B) The effective date of transfer or discharge.</p> <p>(C) The location to which the resident is transferred or discharged.</p> <p>(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .</p> <p>(E) The name of the director and the address, telephone number, and hours of operation of the division.</p> <p>(F) A hearing request form prescribed by the department.</p> <p>(G) The name, address, and telephone number of the state and local long term care ombudsman.</p> <p>(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and</p>			

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	<p>telephone number of the protection and advocacy services commission.</p> <p>Based on record review and interviews, the facility failed to inform the family member of 1 of 3 residents transferred to an acute care center in a sample of 7 of the need to transfer the resident. (Resident F)</p> <p>Finding includes:</p> <p>During the initial tour of the facility, conducted on 06/26/14 between 10:15 A.M. - 11:15 A.M., CNA #15 indicated Resident #F was currently on a rehabilitation unit of a nearby long term care facility after she had fallen in her apartment and suffered a fractured "hip."</p> <p>The clinical record for Resident #F was reviewed on 06/26/14 at 2:30 P.M. Resident #F was admitted to the facility, on 08/16/12, with diagnosis, including but not limited to, osteoporosis, hyperlipidemia, memory loss, vitamin D deficiency, and reaction adjustment issues.</p> <p>Review of nursing progress notes for May 2014, indicated the last entry was documented on 05/23/14, and indicated the physician had given new medication orders. There was no documentation regarding an injury sustained by Resident</p>	R000045	<p>2. (R 045) Family member not notified of resident transfer for emergency treatment a. Facility protocol after the fall of Resident #F was followed to ensure a safe and efficient transfer to the emergency room for evaluation and treatment. Protocol was not followed in regards the nurse-on-call failing to contact family at the time of the incident. Corrective counseling was conducted with this nurse to emphasize the importance of timely communication between the facility and the responsible party of the resident. b. There is potential for all residents to have an accident/incident that may warrant transfer for emergency treatment, including the need for effective and timely communication between our facility and the responsible party. c. Review of the communication process surrounding and incident/accident was conducted at a Personal Support leadership team meeting as part of the investigation of this incident following a family complaint of failure to being notified. The protocol of the nurse being the person to contact family at the time of a potentially serious resident incident, including any transfer for emergency services, was re-emphasized and understood. d. The Personal Support Supervisor will monitor</p>	07/01/2014

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	<p>#F or the resident's transfer from the facility. Interview with the Business Office Manager, Employee #13, on 06/26/14 at 3:00 P.M., indicated the nurse who was on duty at the time of Resident #F's fall would be working on 06/27/14.</p> <p>Interview with LPN #12, on 06/27/14 at 9:30 A.M., indicated she was not working at the time that Resident #F had fallen and been transferred to an acute care facility. LPN #12 indicated she was the licensed nurse "on call." She indicated the CNA working would have documented the fall and transfer in the "Daily Happenings" note and on a facility transfer form. Both forms were kept in an office, in a "binder" but were not part of Resident F's clinical record.</p> <p>The Daily Happenings form for Resident #F, completed by CNA #14, indicated on 05/25/14 at 9:30 P.M., Resident #F had called to inform the nursing assistant she had fallen after having stood on a chair. The resident reported falling on her hip and indicated she was having pain. The documentation included a blood pressure, pulse, and respiration assessment was completed, the nurse on call was notified, and the resident was sent to an acute care center.</p>		all incident/accident reports monthly for compliance regarding situations that warrant timely family notification for resident transfer for emergency treatment.				

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R000116	<p>410 IAC 16.2-5-1.4(a)</p> <p>A transfer form, also completed by CNA #14 indicated the resident was transferred to an acute care center emergency room at 9:45 P.M. The documentation indicated the nurse on call had been notified. However, the resident's family and the Administrator had not been notified.</p> <p>Interview with LPN #12, on 06/27/14 at 9:30 A.M., indicated she was notified of the incident on the evening of 05/25/14 by CNA #14. LPN #12 indicated she did not assess Resident #F but instructed CNA #14 to send the resident to an acute care center. LPN #12 indicated the next day, she realized CNA #14 had not notified the family or the Administrator of the fall and subsequent transfer for Resident #F and had notified both parties.</p> <p>This State tag relates to Complaint #IN00150323.</p>			

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R000121	<p>Personnel - Noncompliance (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interviews, the facility failed to ensure a criminal history inquiries was completed for 1 of 7 employees reviewed. (Employee #16)</p> <p>Finding includes:</p> <p>1. Review, on 06/26/14 at 11:25 A.M., of the employee file for Employee #16, a dietary staff member hired on 05/20/14, there was no completed Criminal history inquiries with the State Police Repository, located in the file.</p> <p>Interview with the Business Office Manager, Employee #13, on 06/26/14 at 2:45 P.M. confirmed no Criminal History Inquiry had been completed because Employee #16 was a minor. Employee #13 was unaware of the procedure with the police departments available to obtain criminal histories of minor individuals.</p> <p>410 IAC 16.2-5-1.4(f)(1-4)</p>	R000116	<p>3. (R 116) Criminal history check not done on a minor a. A criminal history inquiry was conducted on Employee #16 upon becoming aware that this was required for someone hired as a minor for employment. b. All employees, including minors, will need to have the criminal history inquiry conducted as part of the pre-hire process. c. The Business Office Manager will ensure that the criminal history inquiries are conducted on all people being considered for facility employment. d. The Business Office Manager will include the criminal history inquiry as part of the new-hire employee record audit check-list.</p>	08/01/2014			

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	<p>Personnel - Noncompliance</p> <p>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers 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 one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.</p> <p>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.</p> <p>Based on record review and interviews,</p>	R000121	4. (R 121) Staff Mantoux	08/01/2014

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	<p>the facility failed to ensure timely second step Tuberculin skin testing was completed on 3 of 7 newly hired employees reviewed. (Employee #16, #2, and #17)</p> <p>Findings include:</p> <p>1. During a review of the personnel files for Employees #2, 16, and 17, conducted on 05/27/14 at 11:20 - 11:40 A.M. and on 06/30/14 from 9:00 A.M. - 10:00 A.M., the following documentation was noted in the employee files:</p> <p>Employee #2, hired on 02/26/14, had no documentation in the file regarding Tuberculin skin testing.</p> <p>Interview with Employee #13 on 06/27/14 at 2:45 P.M. indicated documentation regarding Employee #16's Tuberculin skin testing was located in the office. Review of the documentation indicated a first step Tuberculin skin test administered on 02/26/14 and read on 02/28/14. Her second step Tuberculin skin test was not administered until 03/24/14.</p> <p>Employee #16, hired on 05/20/14, had a first step Tuberculin skin test administered on 05/20/14 and read on 05/23/14. Her second step Tuberculin</p>		<p>new-hire 2nd step skin tests not timely a. Mantoux records were reviewed for the three employees hired on 2-26-14. All three employees had record of having received the Tuberculin skin testing upon hire and the facility could not therefore identify "Employee #2, hired on 02/26/14, who had no documentation in the file regarding Tuberculin skin testing". Additionally, surveyors identified two different employees (according to start date) as "Employee #16". That being said, the 2nd step Tuberculin skin tests for two employees were not conducted within the required three week time period. b. All staff need to have Tuberculin skin testing done within the regulatory time frames. Two additional nurses were re-certified in conducting Tuberculin skin testing on July 8, 2014 allowing for improved compliance with mandatory time frames. c. System improvements for time frame compliance include nurses scheduling skin tests into shared calendars, e-mail notification to the appropriate departmental supervisor and notification slips given to the new employee as to when they need to return for the 2nd step skin test. d. The Personal Support Supervisor will monitor for compliance on a monthly basis and address any issues related to incomplete or untimely practice in regards to Tuberculin skin testing.</p>				

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R000216	<p>skin test was not administered until 06/27/14 and had not yet been read at the time of the review.</p> <p>Employee #17, hired on 05/20/14, had a first step Tuberculin skin test administered on 05/20/14 and read on 05/23/14. Her second step Tuberculin skin test was not administered until 06/17/14.</p> <p>Interview with the Administrator, on 06/30/14 at 2:30 P.M., indicated he had been without a licensed nurse in an Administrative role and he had been trying to wear both hats (Administrator and Director of Nursing).</p> <p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications.</p>			

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	<p>(d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interviews, the facility failed to ensure their were evaluations completed for self administration capabilities for 3 of 3 residents who administered their own mediations in a sample of 7. (Residents #C, #E, and #F)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #F was completed on 06/26/14 at 2:00 P.M. Resident #F was admitted to the facility on 08/16/12 with diagnosis, including but not limited to, osteoporosis, hyperlipidemia, memory loss, vitamin D deficiency, and reaction adjustment.</p> <p>The most recent Assistance Plan for Resident #F, completed on 05/14/14, indicated the resident required reminders and assistance with self administration. There was no evaluation of the resident's ability to self administer her own medication.</p> <p>Interview with CNA #15, indicated the facility had no specific evaluation of the resident's ability to self administer medications, but just documented the assistance plan regarding medication needs.2. On 6/26/14 at 2:00 P.M., record</p>	R000216	<p>5. (R 216) Need for resident assessment for self-administration of medications a. The identified residents were assessed by our nurses to determine their ability to self-administer medications utilizing the“Medication Self-Administration/Management Assessment” tool. Each had their Assistance Plan modified to indicate the appropriate degree of medication assistance. b. All licensed residents were assessed by our nurses to determine their ability to self-administer medications utilizing the“Medication Self-Administration/Management Assessment” tool (Attachment B). Each had their Assistance Plan modified as necessary to indicate the appropriate degree of medication assistance. c. All new licensed residents will have an initial medication self-administration assessment completed as part of their admission process. Existing residents will have an updated medication assessment completed every six months when their Assistance Plan is updated, or more frequently if a change of condition warrants are-assessment. d. The Personal Support Supervisor will monitor compliance of completion of both the admitting medication assessment and the routine</p>	08/18/2014

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	<p>review indicated Resident E's diagnoses included, but were not limited to, "...hypertension, congestive heart failure, coronary artery disease, atrial fibrillation and macular degeneration...."</p> <p>Review of the "Assessment Tool for Level of Support," dated 9/3/08, indicated the resident was a level I for personal support of medication, he was independent and knows the names of the meds being taken.</p> <p>An assistance plan, dated 5/2/14, indicated the resident required medication set-up from the pharmacy and he was independent with self administration. There was no med self administration evaluation located in the clinical record.</p> <p>3. On 6/27/14 at 10:30 A.M., record review indicated Resident C's diagnoses included, but were not limited to, "...anemia, atrial fibrillation, coronary artery disease, chronic obstructive pulmonary disease, retinal detachment of the right eye, hypertension and hyperlipidemia...."</p> <p>Review of the assessment tool for level of support, dated 8/28/13, indicated the resident was a level III for personal support of medication and required</p>		<p>assessments thereafter. This component will be added to the Nursing Quality Assurance Report (Attachment C) for nursing documentation that will be reviewed with Executive Director on a quarterly basis.</p>				

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	<p>assistance with and observation of taking medications. There was no med self administration evaluation located in the clinical record.</p> <p>An assistance plan, dated 3/10/14, indicated the resident required medication set-up from the pharmacy and he needed assist with self medication. The section of the form, indicating if the resident needed staff to unlock their medication box, hand them their medication packet, and open the tab of their medication packet, was not marked.</p> <p>A "Daily Assistance Record," dated June with no year, indicated the resident received morning and evening med assist daily from June 1st through June 30th. The record did not indicate the name, dosage or frequency of the medication the resident was assisted with.</p> <p>On 6/27/14 at 1:35 P.M., review of the current policy "Assistance with Self Administration of Medication," received from the Administrative Assistant, indicated "...Each resident will be assessed by the nurse as to their ability to self administer medications...Level III, IV, V and VI allows for direct assistance of the staff for cueing, opening packets and observation for self medication...."</p>			

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R000243	<p>On 6/30/14 at 2:55 P.M., an interview with Employee #5 indicated the facility does not do a self administration evaluation for meds that would include if the resident could identify their medication and how to take it. She indicated when the resident is admitted the nurse interviews the resident and completes an assessment tool for their level of support, this includes assistance for medications. She further indicated that a new assessment tool is completed for the resident if they have a change in their level of support.</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 the nursing staff administering medications for 3 of 7 residents reviewed signed for the individual medications administered and the dose administered. (Resident #B, #D and #H)</p> <p>Findings include:</p>	R000243	<p>6. (R 243) Need to list and sign for individual medications a. The three identified residents each now have a revised "Daily Assistance Record" (Attachment D) that includes the names and dosages of each medication, ensuring that nurse/QMA documentation includes greater awareness of each medication that is provided. b. All licensed residents receiving Nurse/QMA</p>	08/01/2014			

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	<p>During the initial tour of the facility, conducted on 06/26/14 from 10:30 A.M. – 11:30 A.M., LPN #2 indicated Resident #B and Resident #D both required nurse medication administration assistance.</p> <p>1. The clinical record for Resident B was reviewed on 06/27/14 at 10:00 A.M. Resident #B was admitted to the facility, on 02/14/14, with diagnosis, including but not limited to, leukemia, coronary artery disease, hypertension, and depression.</p> <p>The physician orders for medications for June 2014 for Resident #B included the following: Levothyroxin 50 mcg (microgram) one tablet every day, metoprolol er (extended-release) 50 mg (milligram) one tablet every day, pantoprazole 20 mg one tablet every day, poly-iron 150 mg one capsule every day, tamsulosin .4 mg one capsule every day, Mirtazapine 15 mg one tablet every bedtime, Finasteride 5 mg one tablet every day, hydrochlorothiazide 12.5 mg one tablet every day, pain relief 325 mg two tablets every four hours as</p>		<p>assistance with medications will be provided the medication safety practice of having each of the names and dosages of their medications listed on the revised "Daily Assistance Record". c. Nurses and QMAs will be in-serviced on utilizing this form prior to August 1, 2014, in order to implement the forms beginning August 1, 2014. Nurses checking in the weekly pill planners will compare the incoming medications from the pharmacy with the medications listed on the Daily Assistance Record. d. The Personal Support Supervisor will provide quality spot checks on a monthly basis to ensure that the accuracy of medications on the form is sustained on an ongoing basis. This component will be added to the Nursing Quality Assurance Report for nursing documentation that will be reviewed with Executive Director on a quarterly basis.</p>				

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	<p>needed.</p> <p>Review of the most recent Assistance Plan for Resident #B, completed on 02/23/14, indicated the resident required nurse/QMA (Qualified Medication Aide) Administration assistance in the morning and at bedtime. The nursing staff were noted to just sign their initials by the corresponding date for "med assist" for morning and bedtime. There was no specific medications or dosages indicated on the form.</p> <p>2. The clinical record for Resident Resident D was reviewed on 06/27/14 at 2:00 P.M. Resident #D was admitted to the facility, on 03/12/09, with diagnosis, including but not limited to frequent falls, constipation, osteoporosis, dementia, and urinary incontinence.</p> <p>The current medication orders for June 2014 for Resident D included orders for the following medications: Synthroid 75 mcg one tablet daily, Alendronate 70 mg one tablet weekly, Doc-q-lace 100 mg one capsule bid as needed, Non-Aspirin 325 mg on tablet twice a day as needed, os-cal 500 mg</p>			

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	<p>and D one tablet twice a day as needed, oxybutynin 5 mng one tablet twice a day, Ropinirole 1 mg one tablet three times a day, Stool Softener 100 mg one capsule twice a day as needed, Tramadol 50 mg one tablet twice a day, Aspirin 81 mg one tablet every day, Donepezil 10 mg one tablet every day, Mirtazapine 15 mg on tablet every day at bedtime, Pravastatin 40 mg one tablet at bedtime, and Ibuprofen 200 mg one – two tablets every six hours as needed.</p> <p>The most recent Assistance Plan for Resident D, completed on 05/08/14, indicated the resident required nurse/QMA Medication Administration assistance.</p> <p>The Daily Assistance Record for Resident D for June 2014 indicated the nursing staff were signing their initials for a Medication assistance in the morning, noon time, evening, and bedtime. The individual medications administered and the dose of those medications was not documented in the clinical record.</p> <p>3. The closed clinical record for Resident #H was reviewed on 06/30/14. Resident #H was admitted to the facility, on</p>						

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	<p>09/29/10, with diagnosis, including but not limited to hypothyroidism, hypertension, osteoporosis, hypercholesterolemia, arthritis, and removal of vertebra of the cervical spine. The resident was discharged from the facility on 05/12/14.</p> <p>The physician orders for May 2014 included orders for the medications Amlodipine 5 mg one a day, Levothyroxin 75 mcg one tablet every day, Metoprolol Tartate 50 mg every day, and Lorazepam .5 mg 1/2 tablet every day as needed, may repeat one time after 2 hours if first dose ineffective.</p> <p>The Assistance Plan for Emily's House (the Dementia Unit), completed for Resident #H on 04/15/13, indicated the resident was to be reminded and assisted with self administration. However, handwritten in the comments section was "meds administered by nurse or QMA."</p> <p>The Daily Assistance Record for April 2014 indicated the nursing staff were documenting their initials for morning medication assistance, but there was no individual medication and dosages</p>			

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R000246	<p>administered documented.</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.</p> <p>Based on record reviews and interviews, the facility failed to ensure the licensed nurse was notified prior to assisting residents with the administration of as needed medications. This deficient practice affected 2 residents in a sample of 7. (Residents B and C)</p> <p>Findings include:</p> <p>1. During the initial tour of the facility, conducted on 06/26/14 from 10:30 A.M. - 11:30 A.M., LPN #2 indicated Resident #B required medication administration assistance.</p> <p>The clinical record for Resident B was reviewed on 06/27/14 at 10:00 A.M. Resident #B was admitted to the facility on 02/14/14 with diagnosis, including but not limited to, leukemia, coronary artery disease, hypertension, and depression.</p>	R000246	<p>7. (R 246) Lack of authorization from nurse for assisting with PRN medications</p> <p>a. The two identified residents were discussed as part of the departmental in-service for nurses, QMA's and CNAs on July 7, 2014. A handout (Attachment E) was provided based on state-approved facility policy and procedure that clarifies when a nurse must be called regarding assisting with resident's request for PRN medications and what appropriate surrounding documentation is to include. b. The educational in-service of July 7, 2014 applies to all residents receiving assistance with PRN medications in our facility. c. Nurses will audit QMA and CNA documentation of PRN medications and cross-check that documentation with phone calls they receive regarding residents request for PRN medication</p>	08/18/2014			

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	<p>The physician orders for medications for June 2014 for Resident #B included the following: Pain Relief (Tylenol) 325 mg two tablets every four hours as needed.</p> <p>Review of the most recent Assistance Plan for Resident #B, completed on 02/23/14, indicated the resident required nurse/QMA [Qualified Medication Aide] Administration assistance in the morning and at bedtime.</p> <p>Review of the PRN (as needed) tracking form for the Tylenol 325 mg two tablets every 4 hours as needed for pain indicated the resident had received the medication on 04/01/14, 04/02/14, 04/03/14, 04/04/14, 04/06/14 and 04/07/14. There was no documentation of nurse authorization prior to the medication administration for 3 of the 6 times when a Resident Assistant (Certified Nursing Assistant) or Qualified Medication Aide administered the medication. 2. On 6/27/14 at 10:30 A.M., record review indicated Resident C's diagnoses included but were not limited to "...anemia, atrial fibrillation, coronary artery disease, chronic obstructive pulmonary disease, retinal detachment of the right eye, hypertension and hyperlipidemia..." Further review of the clinical record indicated Resident C</p>		<p>assistance. This will be done weekly for 2 months and then monthly thereafter. d. The Personal Support Supervisor will ensure that the nursing audits occur on the agreed upon schedule and report her findings quarterly to the Executive Director as part of the Nursing Quality Assurance Report.</p>	

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	<p>took Norco (pain medication) 5/325 mg (milligrams) 1 tablet by mouth every 6 to 8 hours as needed for pain.</p> <p>Review of the assessment tool for level of support, dated 8/28/13, indicated the resident was a level III for personal support of medication and required assistance with and observation of taking meds.</p> <p>Review of the "PRN Tracking Form" indicated that Employee #6 administered Norco 5/325 mg 1 tablet on 3/18/14 at 1:40 P.M., there was no documentation on the prn tracking form that the nurse was notified prior to giving the medication. On 4/19/14 at 10:40 P.M., Employee #7 administered Norco 5/325 mg 1 tablet, there was no documentation that the nurse was notified prior to giving the medication. On 6/14/14 at 8:45 P.M., Employee #8 administered Norco 5/325 mg 1 tablet, there was no documentation that the nurse was notified prior to giving the medication.</p> <p>Review of the daily happenings and nurse notes for the above dates indicated no record of symptoms or that the licensed nurse was contacted for permission to administer the medication.</p> <p>On 6/27/14 at 10:45 A.M., an interview</p>						

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R000301	<p>with LPN #9 indicated that the nurse should be contacted prior to an RA (resident assistant) or QMA (qualified medication assistant) administering any prn (as needed) medication. After the RA or QMA notifies the nurse and receives approval to give the prn medication they should document on the prn tracking form that the nurse was notified. LPN #9 further indicated that the prn medication should probably be documented in the daily happenings note as well.</p> <p>Review of the current "Assistance with Self Administration of Medication Policy" received from the Administrative Assistant on 6/27/14 at 1:35 P.M., indicated "...When a resident requests a PRN medication, the nurse or nurse on call must be contacted, unless a specific PRN medication is requested by name and assistance is no different than any other prescribed medication...."</p> <p>410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription.</p>			

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	<p>If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.</p> <p>Based on observation, record review and interview the facility failed to label medications with the dosage and/or strength of the medications to be administered for 3 of 5 residents during a medication pass. (Resident #1, Resident #2 and Resident #3)</p> <p>Findings include:</p> <p>1. On 6-26-14 at 11:15 A.M., LPN #1 was observed opening a pill pack for Resident #1, labeled Thursday-Noon. The LPN compared how many pills were in the pill pack (4) to a form titled "Medication Information" attached to the pill pack. The form indicated 4 pills were to be administered by the nurse at noon. The form included; the resident's name, prescription (name of drug), dose, number of pills, times per day, comments (description of medication), and schedule (morning, noon, evening or bed-time). The medications to be administered to Resident #1 at noon per the "Medication Information" form included "...Vit [Vitamin] B-12 1000, Vit D-3 1000, Vitamin MVI [multi-vitamin] and Ferr [Ferrous] Sulf. [Sulfate]...." The LPN indicated that pharmacy fills the pill packs and completes the Medication</p>	R000301	<p>8. (R 301) Need for accurate labeling of medications a. The failure to label medications correctly for Residents 1, 2 & 3 was corrected at the time of the survey. The surveyor's call to the pharmacist supplying our residents' medications was helpful in addressing the pharmacy's responsibility for accurate labeling of medications. b. All resident pill planners were checked by the nurse to assess for medication labeling compliance. Any planners not containing all required aspects of medication labeling were corrected to contain needed information. c. All resident pill planners are checked upon receiving them each week from the pharmacy. Added attention will be placed on ensuring that medication labeling of each resident's pill planner contains all the required information. d. Any failure to properly label medications will be documented in on a Medication Incident Report. The Personal Support Supervisor will monitor compliance on a weekly basis for 4 weeks then provide spot checks for ongoing compliance. She will ensure that inaccuracies or omissions are addressed so that all required drug information is current and accurate.</p>	08/18/2014			

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	<p>Information form. When I asked the LPN how she knew the resident was getting the right dose she indicated, " that's a good question." She agreed the Medication Information form attached to the medication pill pack should have the dose of the medication included in its dispensing information.</p> <p>On 6-26-14 at 11:55 A.M., a physician's order, dated 7-16-12, indicated Resident #1 was to receive "...Vitamin B-12 1,000 mcg [micrograms], take one tablet PO [by mouth] QD [everyday]...." However, a form, dated June 2014, untitled and resembling a MAR (medication administration record), listed all the medication names, doses, routes and times the resident was to receive medications. This form indicated the resident was to receive one Certa-vite (muti-vitamin) at noon, Vitamin B-12 100 mcg. (micrograms) daily, Vitamin D 1000 units PO BID (twice a day) and Ferrous Sulf. 325 mg (milligrams) PO TID (three times a day). The form indicated the orders were reviewed and noted by an LPN and a Pharmacist.</p> <p>During an interview, on 6-26-14 at 12:15 P.M., the Charge LPN #2 indicated the pharmacy fills the pill packs and when the packs are received at the facility a "double check" was completed on each</p>		Compliance in this area will be reported to the Executive Director on a quarterly basis as part of the Nursing Quality Assurance Report.	

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NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING APARTMENTS	STREET ADDRESS, CITY, STATE, ZIP CODE 1212 WATERFORD CIR GOSHEN, IN 46526
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	<p>medication. The nurse would open each pill pack "day" and "time" to verify the number of pills and the pill's description were correct. If a discrepancy was noted, the nurse would verify the pill on "Pill ID" [an electronic medication reference] or call the pharmacist. The LPN further indicated dosing was not checked as they "trust" the pharmacy to have the correct dose in the pack. She indicated this was " just like you would trust a bubble pack pill dosages were correct." She further indicated the pills were not checked against the form that resembled a MAR at the time of administration. The LPN #2 was unable to explain why the MAR indicated the resident received 100 mcg of Vitamin B-12 and the Medication Information form stated 1000. When asked why some of the medications Resident #1 received had no dosage amount on the Medication Information form she indicated "it probably should".</p> <p>During a telephone interview, on 6-26-14 at 12:25 P.M., Pharmacist #3 indicated he had an order for Resident #1 to receive 1000 mcg. of Vitamin B-12 daily. He further indicated the MAR form was generated by the pharmacy staff and had all the medication orders on it. When asked about the Vitamin B-12 order on the MAR he indicated the form had an incorrect dose on it and would be</p>			

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	<p>changed immediately. He further indicated the resident had been receiving the correct dose as Vitamin B-12 does not come in a 100 mcg. dose. Pharmacist #3 indicated the Medication Information should include the dosage amount and include units, micrograms and milligrams etc. He could not explain why the pharmacist who reviewed the MAR in June did not catch the error.</p> <p>2. On 6-26-14 at 3:10 P.M., LPN #2 was observed opening a pill pack lid for "Thursday Evening" and removed 4 pills from the pill pack for Resident #2. The Medication Information form indicated the medications were acetaminophen 500 mg. give 2 TID, Docusate BID and Dillofenal 75 mg. BID. The MAR (Medication Administration Record) indicated Resident #2 medication's for evening were "...MAPAP [acetaminophen] 500 mg. Take 2 tablets by mouth three times a day, docusate sodium 50 mg. Take 1 capsule by mouth twice daily and diclofenac 75 mg. Take 1 tablet by mouth twice daily...." The LPN #2 confirmed that the Medication Information did not include the complete dosage information</p> <p>3. On 6-26-14 at 3:15 P.M., LPN #2 was observed opening a pill pack lid for "Thursday Evening" and removed 4 pills</p>			

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R000409	<p>from the pill pack for Resident #3. The Medication Information form indicated the medications were levetiracetam 500 BID, calcium 600 BID, omeprazole 40 once a day and docusate 100 BID. The MAR indicated Resident #2 medication's for evening were "... levetiraceta 500 mg Take 1 tablet by oral route 2 times a day, calcium 600 mg Take 1 tablet by mouth twice a day and Doc-Q-Lace 100 mg. Take 1 capsule by mouth twice a day...." Again, the LPN #2 confirmed that the Medication Information did not include the complete dosage information.</p> <p>On 6-27-14 at 1:50 P.M. a policy titled "Waterford Crossing Assisted Living Medication Labeling," dated 5-27-2010, indicated "... Labeling of prescription drugs shall include the following: Resident's name, Physician's name, Prescription number, Name and strength of the drug...."</p> <p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of</p>			

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	<p>tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on record review and interview, the facility failed to ensure there was an annual health statement for 1 resident in a sample of 7. (Resident E)</p> <p>Finding includes:</p> <p>On 6/26/14 at 2:00 P.M., record review indicated Resident E's, who was admitted on 09/16/08, had diagnoses included but were not limited to "...hypertension, congestive heart failure, coronary artery disease, atrial fibrillation and macular degeneration...." Further review of the clinical record indicated there was no annual health statement from a physician, in the past year. There was a physical completed in 2008 when the resident was admitted.</p> <p>On 6/30/14 at 3:00 P.M., an interview with Employee #5 indicated the resident did not have an annual health statement indicating the resident was free of communicable diseases.</p>	R000409	<p>9. (R 409) Need for annual health statement stating resident is free from infectious tuberculosis a. An annual health assessment form was created after the survey exit that was then used to verify that Resident #1 was free from any evidence of tuberculosis in an infectious state (Attachment F). This form was faxed to the resident's physician for signature and physician awareness. b. All residents are required to have an annual health assessment. Each resident will be assessed at the time of their annual PPD skin test to assess for the possible presence of infectious tuberculosis. c. All residents receive an annual PPD skin test to assess for possible presence of infectious tuberculosis. The results of this test, along with nursing assessment for any other signs and symptoms of tuberculosis will be faxed, scanned or mailed to the physician for his/her review, further direction and record keeping. A signed copy will be returned to the facility. d. The Personal Support Supervisor will monitor that annual health assessments take place with each resident's annual PPD skin test. Compliance will consist of health assessments being sent out to the physician and signed</p>	08/18/2014			

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			health assessments being returned to the facility. Compliance in this area will be reported to the Executive Director on a quarterly basis as part of the Nursing Quality Assurance Report.		