

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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
--------------------	--	---------------	---	----------------------

F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00169401.</p> <p>Complaint number IN00169401-Substantiated. Federal/State deficiencies related to the allegation are cited at F-281.</p> <p>Survey date: March 13, 2015</p> <p>Facility number: 000510 Provider number: 155507 AIM number: 100285440</p> <p>Survey team: Angel Tomlinson, RN-TC Barbara Gray, RN Diana Sidell, RN Leslie Parrett, RN</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census payor type: Medicare: 1 Medicaid: 24 Other: 4 Total: 29</p>	F 000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance. Due to the low scope and severity of this survey findings, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2015
NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353		
(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	
F 281 SS=E Bldg. 00	<p>Sample: 16</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on March 20, 2015 by Cheryl Fielden, RN.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview and record review the facility failed to ensure residents medications were prepared and administered in a safe manner as three nurses preset up medications for 16 of 29 residents residing in the facility that were administered by one nurse and failed to have an assessment, education and an physician order for a resident to self administer medications for 1 (Resident #C) of 3 residents sampled for medication review in a total sample of 16 (Resident #B, Resident #C, Resident #D, Resident #E, Resident #F, Resident #G, Resident #H, Resident #I, Resident #J, Resident #K, Resident #L, Resident #M, Resident #N, Resident #O, Resident #P</p>	F 281	F281 requires that services provided or arranged by the facility must meet professional standards of quality.1. No residents were harmed. Staff are no longer pre-setting medications to be passed at a later time. Medications are no longer being left at bed side for self administration for Resident #C. Policies and Procedures for Medication Administration and Self Administration of Medication were reviewed with no changes made.2. All residents have the potential to be affected, thus the following corrective actions have been taken;3. All licensed nurses received inservice training on March 18, 2015 regarding policies and procedures for Medication	03/18/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/13/2015	
NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353			
(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>and Resident #Q).</p> <p>Findings include:</p> <p>During observation on 3/13/15 at 6:30 a.m., the 100 hallway medication cart had 10 plastic medication cups in the top drawer with multiple pills in each cup with Resident #C, Resident #D, Resident #E, Resident #F, Resident #G, Resident #H, Resident #I, Resident #J, Resident #K and Resident #l's name labeled on the outside of the medication cup.</p> <p>Interview with LPN #1 on 3/13/15 at 6:30 a.m., indicated she was the only nurse for dayshift. LPN #1 indicated she came in at 6:00 a.m. LPN #1 indicated the duties she had performed since she came to work was discontinued an Intravenous therapy (IV), flushed the port and received report from the night shift nurse. LPN #1 indicated she had not passed any medications and would start her medication pass around 7:00 a.m. LPN #1 indicated RN #2 and RN #3 were the night shift nurses that had been working.</p> <p>Interview with RN #3 on 3/13/15 at 6:50 a.m., indicated she had set up the medications for the dayshift nurse to administer. RN #3 indicated she did not set up the dayshift nurses medication all</p>		<p>Administration and Self Administration of Medication (Attachment A).4. The DON or designee will conduct observations to ensure no medications are being preset by nurses for other nurses to administer on scheduled days of work daily for two weeks, three times a week for two weeks, then weekly until compliance is maintained for six consecutive months (Attachment B). The results of these audits will be reviewed during the quarterly Quality Assurance Committee meeting and the plan of action adjusted accordingly, if warranted.The DON or designee will conduct observations of medication pass of 5 residents to ensure medications are administered per the physician order daily on scheduled days of work for two weeks, three times a week for two weeks, one time a week for one month and monthly thereafter until compliance is maintained for six consecutive months (Attachment C). The results of these audits will be reviewed during the quarterly Quality Assurance Committee meeting and the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before March 18, 2015.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>the time. RN #3 indicated usually she would set up the medications and then stay over on dayshift and pass the medications at 7:00 a.m., but on 3/13/15 she did not stay over and pass the medications she had set up. RN #3 indicated she set up the medications for the dayshift nurse to try and help out. RN #3 indicated she had set up medications before and another nurse would help pass the medications out.</p> <p>Interview with RN #2 on 3/13/15 at 7:00 a.m., via the telephone, RN #2 confirmed her name. When informed the survey team was in the facility and would like to interview about some concerns, the telephone connection was disconnected.</p> <p>During observation on 3/13/15 at 7:20 a.m., the medication cart for the 200 hallway had 6 plastic medication cups with multiple medications in them. LPN #1 indicated she had set the medications up earlier and she had also preset up the medications in the 100 hallway medication cart. LPN #1 indicated she preset her medications so they would be ready for residents who wanted their medications "right now".</p> <p>During observation and interview on 3/13/15 at 7:58 a.m., LPN #1 had Resident #B's medication preset up in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>200 hallway cart. LPN #1 demonstrated how she rechecks all the medication in the cup with the blister pack to ensure they were the correct medications.</p> <p>Interview with LPN #1 on 3/13/15 at 9:07 a.m., indicated there were 16 residents who had preset medications. LPN #1 indicated she did preset up medications occasionally so the residents did not have to wait on their medications. LPN #1 indicated some residents get upset if they have to wait for their medications. LPN #1 indicated she had asked the Director Of Nursing (DON) if presetting up medications were allowed and was told by the DON it was ok to do under certain circumstances. LPN #1 indicated she came to the facility on 3/13/15 at 5:30 a.m. and preset up the medications, but did not clock in for duty until around 6:00 a.m. LPN #1 indicated when she was interviewed regarding the duties she had preformed since coming to work she did not disclose that she had preset up the medications because she thought it was related to "hands on for residents" only. LPN #1 indicated RN #2 and herself stood beside each other and preset up the 100 hallway medications together. LPN #1 indicated RN #3 and herself had stood beside each other and preset up the medications for the 200 hallway together. LPN #1 indicated all 16</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>residents who had preset up medications were triple checked and given to the residents.</p> <p>Interview with the DON on 3/13/15 at 9:45 a.m., indicated she was aware nurses were presetting up medications, but was unaware the nurses were presetting up medications for other nurses. The DON indicated she had directed the nurses it was ok to preset up a few medications and to mark the medication good with the residents name.</p> <p>Interview with LPN #1 on 3/13/15 at 10:25 a.m., indicated the other five residents on the 200 hallway that had preset up medications were Resident #M, Resident #N, Resident #O, Resident #P and Resident #Q.</p> <p>The medication administration policy provided by the DON on 3/13/15 at 9:05 a.m., indicated the preparation included, but were not limited to, "Never pre-pour medications". The guidelines for medication administration included, but were not limited to, "medications are to be prepared just prior to administration", "never pre-pour medications for more than one medication pass" and "all medications are to be given by the person who prepared the dose".2. Resident #C's record was reviewed on 3/13/15 at 10:00</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>a.m. Diagnoses included but were not limited to, acute heart failure, history of tricuspid valve replacement, endocarditis on bioprosthetic valve, large vegetative growth on bioprosthetic valve, cardiomegaly, hypertension, pulmonary edema, cirrhosis of the liver, hepatitis B and C, pulmonary edema, cavity lung lesion, anxiety, and depression.</p> <p>Resident #C's Quarterly Minimum Data Set (MDS) assessment dated 2/20/15, indicated she was able to make herself understood and had the ability to understand others. She was cognitively intact in her daily decision making skills.</p> <p>Resident #C's Medication Record documentation indicated on 3/13/15 at 8:00 a.m., she had received baraclude 1 milligram (mg) tablet by mouth (po) for hepatitis B, flonase 0.05% nasal spray (2 sprays each nostril) for nasal congestion, arixtra (Fondaparinux) 2.5 mg/0.5 milliliters (ml) syringe subcutaneous injection for prosthetic valve, Miralax powder 17 grams po for bowel motility, aldactone 100 mg tablet po for edema, colace 100 mg capsule po for bowel motility, famotidine 20 mg tablet po for gastrointestinal esophageal reflux disease, magnesium oxide 400 mg tablet (2 tablets) po for a supplement, potassium chloride extended release 20</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>milliquivillent tablet po for diuretic use/hypertension, torsemide 20 mg tablet po for edema, lactulose 10 gram/15 ml solution (45 ml) po for bowel motility, ativan 0.5 mg tablet po for anxiety, and hydromorphone 4 mg tablet (3 tablets) po for pain.</p> <p>On 3/13/15 at 9:55 a.m., Resident #C was observed in her bedroom with dim lighting, lying on her left side in bed with the head of her bed raised approximately 30 degrees. A medication cup containing medication and a syringe was lying on her bedside table next to her bed. She counted the medications in the cup and indicated it contained 14 pills and spelled the word Fondaparinux contained in the syringe. She indicated sometimes she administered her own medications, including injections. The medications had been left on Resident #C's bedside table for her to self-administer earlier that morning but she had not spoken to the nurse and could not recall which nurse had left them.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 3/13/15 at 10:35 a.m., indicated no residents at the facility self administered their own medications.</p> <p>An interview with RN #4 on 3/13/15 at 11:00 a.m., indicated no residents at the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>facility self administered their own medications and medications should never be left on a resident's bedside table. She indicated nursing staff were responsible for administering all of Resident #C's medications.</p> <p>An interview with Resident #C on 3/13/15 at 11:05 a.m., with RN #4 present, indicated she had taken the medications in the medication cup and had given herself the Fondaparinux Sodium Solution injection in her abdomen after speaking with the surveyor earlier that morning. After giving herself the Fondaparinux injection she had given the used syringe to LPN #5 to discard.</p> <p>An interview with the ADON on 3/13/15 at 11:10 a.m., indicated she was unable to locate any documentation indicating Resident #C could self administer her own medications.</p> <p>An interview with LPN #5 on 3/13/15 at 11:25 a.m., indicated Resident #C had given her the used syringe to discard earlier that morning at approximately 10:30 a.m., after Resident #C placed her call light on for some water. LPN #5 had not dispensed Resident #C's medications but LPN #1 who had already left for the day would have administered the 8:00 a.m., medications. When LPN #5 had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>taken the used syringe from Resident #C earlier that morning she had questioned Resident #C if she had given herself her injection and Resident #C responded "yes." LPN #5 had never allowed Resident #C to administer her own medications but she had been informed by staff during training Resident #C could administer her own medications. She could not recall which staff had informed her of that information.</p> <p>A Medications, Self-Administration policy and procedure provided by the ADON on 3/13/15 at 12:15 p.m., indicated the following: " Purpose: To allow residents who are capable and desire to do so, the opportunity to self-administer medication(s). Policy: The facility acknowledges the right of each resident to self-administer medications unless the interdisciplinary team has evaluated the resident and judged that self-administration would present a danger to the resident or others. Procedure: 1. The interdisciplinary team, or a representative thereof, will ask the resident whether he/she wishes to self-administer medications at the time of admission to the facility. If the resident wishes to defer this responsibility, medication will be administered per nursing personnel as per usual. Should the resident note a desire to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>self-administer medication(s), the interdisciplinary team will evaluate the resident for the cognitive, physical and visual ability to accomplish this task. If after evaluation and return demonstration, the interdisciplinary team determines that the resident is unable to carry out this responsibility, the interdisciplinary team may withdraw the right to self-administer medications. 2. If the evaluation reveals the resident is capable of participation in self-administration, a physician order reflecting the same shall be obtained to specify which medications may be self-administered by the resident. Medication self-administration shall be addressed on the resident's plan of care. 3. Before participating in self-administration, the resident will be provided education, if necessary, by nursing personnel to include but not be limited to the following: -demonstration of correct technique for administration -demonstration of knowledge of the name and frequency of medication to be administered -recognition of the colors and shapes of medication -basic reason why he/she is taking the medication -demonstration of knowledge of common side-effects of the medication. 4. Medications will be stored in a manner to prevent potential access to confused residents in the facility. 5. It is not</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>necessary that the nurse actually observe the resident consuming/injecting/applying the medication. However, parameters such as blood glucose, blood pressure, pulse and lab values should be monitored by nursing personnel as necessary to ascertain the resident's compliance with self-administration. The resident's room shall periodically be observed by nursing personnel for unconsumed/unused or inappropriately stored medications. 6. Residents who self-administer should be monitored weekly by nursing personnel to include: a reconciliation of medications in an effort to identify any missed dose; medications packaged in blister-packs can be dated when they are checked to facilitate future audits; audit of PRN (as needed) meds (medications) to determine usage or non-usage as well as expiration dating; and determination of a need to reorder. 7. Controlled substances may be excluded from self-administration at the discretion of the interdisciplinary team. 8. all residents participating in self-administration shall be reassessed at least quarterly at the time of comprehensive careplan review for continued ability to self-administer medications."</p> <p>The Potter and Perry's Fundamentals of Nursing, 6th Edition, indicated "...To</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155507	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SYCAMORE SPRINGS REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN 47353
--	---

(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>administer medication safely to clients certain cognitive skills are essential. The nurse accepts full accountability and responsibility for all actions that are taken; this includes the administration of medications (Minnesota Nurses Association, 2001)...The nurse is also responsible for ensuring that clients who will self-administer medications have been properly informed about all aspects of self-administration...Nurses administer only the medications they prepare. If an error occurs, the nurse who administers the medication is responsible for the error...Clients who self-administer medications should keep them in their original labeled containers, separate from other medications, to avoid confusion...."</p> <p>This federal tag relates to Complaint IN00169401.</p> <p>3.1-35(g)(1)</p>			