STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155448	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOWELL HEALTHCARE	710 MICHIGAN ST LOWELL, IN 46356

(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
F000000	This visit was for the Recertification and State Licensure Survey. Survey dates: March 31, April 1, 2, 3 and 4, 2014 Facility Number: 000361 Provider Number: 155448 AIM Number: 100266340 Survey Team: Heather Hite, RN - TC Jennifer Redlin, RN Caitlyn Doyle, RN Julie Ferguson RN (March 31, April 1, 2, and 3, 2014) Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 4 Medicaid: 62 Other: 11 Total: 77 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on April	F000000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after April 25, 2014.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	10, 2014, by Janelyn Kulik, RN.			

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F000164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. Based on observation, record review, and interview, the facility failed to ensure privacy was maintained during a glucometer test (a test to check blood sugar) and insulin administration during medication pass for 1 of 1 residents reviewed for privacy. (Resident #22)	F000164	**F164 – Personal Privacy/Confidentiality of Records** It is the practice of this provider that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records. **What corrective action(s) will be accomplished for those**	04/25/2014

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	Findings include: During an observation of a glucometer test and insulin medication administration on 4/2/14 at 11:48 a.m., RN #1 prepared to check Resident #22's blood sugar. Resident #22 had just returned from an activity and was seated in his wheelchair near RN #1's medication cart in the hallway. RN #1 approached the resident and indicated she was going to perform a glucometer test. RN #1 performed the glucometer test while the resident was seated in his wheelchair in the hallway, a public area. Prior to completing the glucometer test, RN #1 failed to ask the resident if he preferred to have the test completed in the hallway. RN #1 drew up ordered insulin dose and indicated to the resident she was going to administer his insulin. RN #1 lifted up the resident's shirt, so that his abdomen was exposed, cleaned the area with an alcohol wipe, and administered the insulin injection. At the time the insulin injection was given the resident remained seated in his wheelchair near RN #1's medication cart in the hallway, a public area. Prior to		**residents found to have been affected by the deficient practice:** *Resident #22* – has been receiving his medications and treatments in a private setting to maintain privacy. This resident experienced no negative outcome as a result of this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. No other residents are receiving their insulin or glucometer testing in the hallway. All nurses will be in-serviced on or before 4/25/14. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to medication and insulin administration. This in-service will also include review of the policy related to administration of medications such as insulin and treatments such as glucometer testing in a private setting. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All nurses will be in-serviced on or before 4/25/2014. This in-service will be conducted by the DNS/designee and will include review of the facility policy related to medication and treatment administration. This	

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	administering the insulin, RN #1 failed to ask the resident if he preferred to have the medication administered in the hallway. At the time of the glucometer test and insulin administration observation there was a CNA and a therapy employee present near the medication cart in the hallway. During an interview on 4/2/14 at 12:00 p.m., RN #1 indicated Resident #22 preferred to have glucometer test completed and insulin administered near medication cart in the hallway because he wanted to get it over with quickly. Interview with Resident #22 on 4/3/14 at 2:36 p.m., indicated the resident was unable to answer screening questions appropriately and was not interviewable. Resident #22's record was reviewed on 4/2/14 at 12:15 p.m. The resident's diagnoses included, but were not limited to, dementia and insulin dependent diabetes mellitus. Review of the resident's current care plans on 4/2/14 at 12:15 p.m. lacked evidence to indicate it was his preference to receive glucometer		in-service will also include review of the policy related to administration of medications such as insulin and treatments such as glucometer testing in a private setting. DNS/designee will conduct rounds to make sure residents are receiving glucometer tests and insulin injections in a private area. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility CQI program. The DNS/designee will be responsible for completion of the Skills Validation Audit tool titled, “Medication Pass Procedure” no less than 5 times per week for 3 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 4/25/14.	

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	tests and insulin administration near the medication cart in the hallway. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 1/30/14, indicated the resident was moderately cognitively impaired. The Brief Interview for Mental Status (BIMS) had not been completed due to the resident being rarely or never understood. A Social Service Note, dated 2/3/14, indicated the resident rarely understood others. A Social Service Note, dated 11/8/13, indicated the resident had moderate cognitive impairment. There was lack of evidence in the resident's record to indicate it was his preference to receive glucometer tests and insulin administration near the medication cart in the hallway. During an interview on 4/3/14 at 11:20 a.m., the Director of Nursing Services (DNS) indicated the resident preferred to have glucometer tests completed and insulin administered near the medication cart. She further indicated Resident #22's care plan had been updated to reflect this preference on 4/2/14, after it had been brought to the staff's attention.			

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	3.1-3(p)(2)			

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F000332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 10 residents observed during 5 medication pass observations. Four errors in medications were observed during 34 opportunities for errors in medication administration. This resulted in a medication error rate of 11.76%. (Residents #93, #60, and #87) Findings include: 1. During an observation of a medication administration pass on 4/3/14 at 8:48 a.m., LPN #1 prepared Resident #93's medications, which included Nexium powder (medication used to treat stomach reflux) 40 milligrams (mg) and digoxin (cardiac medication) 0.125 mg. LPN #1 indicated the resident was to receive his medications through his g-tube (feeding tube). LPN #1 entered the resident's room and turned off the resident's tube feeding, which was running at the time. LPN #1 disconnected the tube	F000332	**F332 – Free of Medication Error Rates of 5% or More** It is the practice of this provider to ensure that it is free of medication error rates of five percent or greater. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** *Resident # 93* – The physician and responsible party were notified of medication errors involving the Nexium and Digoxin. New orders received to discontinue continuous feeding and to initiate bolus feeding 5 times a day and hold one hour after administering Nexium. The Digoxin order was clarified to check apical pulse for 60 seconds prior to administration and to hold if less than 60 BPM. The responsible party was informed of this resident's medication orders. This resident has been receiving medication per physician's order and experienced no negative outcome as a result of this finding. *Resident #60* – The physician and responsible party were notified of Artifical Tears not administered as ordered. Resident #60 has been receiving	04/25/2014

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	feeding from the g-tube, checked the resident's g-tube for placement, and flushed the tube with water. LPN #1 administered the resident's medications one at a time, including the Nexium medication, but did not administer the digoxin medication. LPN #1 flushed the g-tube with 5 milliliters (ml) of water between each medication. LPN #1 checked Resident #93's left carotid pulse for 30 seconds. LPN #1 indicated the resident's pulse was within required parameters and administered the digoxin medication through the g-tube. LPN #1 flushed the resident's g-tube with 30 ml of water, reconnected the tube feeding to the g-tube, and restarted the tube feeding. During an interview with LPN #1, after the observation, LPN #1 indicated the digoxin medication order indicated to check the pulse prior to administration and hold the medication if the pulse was less than 60. She indicated the Physician ' s Order did not indicate where or for how long to monitor the pulse. LPN #1 indicated she was not aware of any specific orders to hold the		Artificial Tears per physician's order. The physician and family were informed of this resident's medication orders. This resident experienced no negative outcome as a result of this finding. *Resident #87* - The physician and responsible party were notified of medication errors involving the Digoxin. The Digoxin order was clarified to check apical pulse for 60 seconds prior to administration and to hold if less than 60 BPM. The responsible party was informed of this resident's medication order. This resident has been receiving medication per physician's order and experienced no negative outcome as a result of this finding. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** All residents have the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team. This audit will include review of each resident's most recent monthly Physician's Orders and Medication Administration Record. This audit will ensure that any resident receiving medications requiring specific monitoring of vital signs prior to administration of medications and/or special instructions for administration of medications have been reviewed and clarified with the physician and are clearly	

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	resident's tube feeding prior giving Nexium. Resident #93's record was reviewed on 4/3/14 at 9:45 a.m. The resident's diagnoses included, but were not limited to, atrial fibrillation and gastroesophageal reflux disease (GERD). The Physician's Orders, dated 4/2014, indicated an order for digoxin 0.125 mg 1 tab per peg tube once daily at 9 a.m. There was no order to check the pulse prior to administration of the medication. The Physician's Orders, dated 4/2014, indicated an order for Nexium powder 40 mg 1 packet per peg tube once daily at 9 a.m. A professional resource, titled, "Nursing 2014 Drug Handbook", page 535, reviewed on 4/3/14 at 10:00 a.m., indicated, " Nexium...Administration...give drug at least 1 hour before meals..." 2. During an observation of a medication administration pass on 4/2/14 at 4:45 p.m., LPN #2 prepared Resident #60's medications, which included Seroquel (antipsychotic medication) 25 mg and dilitazem		noted on the Medication Administration Record for each individual resident. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** A mandatory nursing in-service will be conducted on or before 4/25/14 by the DNS/designee. This in-service will include review of the facility policy related to Medication Administration. All nursing staff will be re-educated on the process of proper administration of medications including but not limited to best practice guidelines for obtaining apical pulse prior to Lanoxin administration and following special instructions such as administration of medications prior to meals/tube feedings. The nurses will also be re-educated/in-serviced on the process of ordering, obtaining and administering medications timely per physician's order. In addition, the DNS and/or member of the Nurse Management Team will be responsible for review of the MARs/TARs to ensure special instructions are being followed, physicians are being notified for results outside the ordered parameters and that medications are being administered timely and per physician's order. Nurses are	

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	(cardiac medication) 60 mg. LPN #2 administered the medications to Resident #60. Resident #60's record was reviewed on 4/2/14 at 4:50 p.m. The resident's diagnoses included, but were not limited to, coronary artery disease and insulin dependent diabetes mellitus. The Physician's Orders, dated 4/2014, indicated an order for Artificial Tears, one drop both eyes TID (three times a day), at 6 a, 12 p, and 4 p. During an interview with LPN #2 at 4:55 p.m. on 4/2/14, she indicated she had not given the Artificial Tears as ordered because they had not arrived from the pharmacy yet. Review of the Medication Administration Record (MAR) dated 4/2014, indicated the Artificial Tears had been administered as ordered 4/1/14 and at 6 a and 12 p on 4/2/14. Continued interview with LPN #2 at 5:07 p.m. on 4/2/14, indicated she had not administered the Artificial Tears because she could not find them in the medication cart and		evaluated on their proficiency with Medication Administration policies upon hire, annually during the Skills Validations check-offs and throughout the year during medication pass observations. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Ongoing compliance with this corrective action will be monitored though the facility CQI program. The DNS/designee will be responsible for completion of the Skills Validation Audit tool titled, “Medication Pass Procedure” no less than 5 times per week for 3 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance Date = 4/25/14.	

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	thought the medication had not arrived from the pharmacy yet. She further indicated she had since found the Artificial Tears and would go administer them. 3. During an observation of a medication administration pass on 4/3/14 at 9:31 a.m., LPN #1 prepared Resident #87's medications, which included digoxin 0.125 mg. LPN #1 entered the resident's room and checked the resident's left radial pulse for 30 seconds. LPN #1 indicated the resident's pulse was within required parameters and administered the digoxin medication. Resident #87's record was reviewed on 4/3/14 at 9:50 a.m. The resident's diagnoses included, but were not limited to, congestive heart failure and hypertension. The Physician's Orders, dated 4/2014, indicated an order for digoxin 0.125 mg 1 tab by mouth once daily at 9 a.m., hold if heart rate < (less than) 60. A professional resource, titled, "Nursing 2014 Drug Handbook", page 442, reviewed on 4/3/14 at 10:00 a.m., indicated,			

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	"Digoxin...Administration...before giving drug, take apical-radial pulse for 1 minute..." 3.1-25(b)(9) 3.1-48(c)(1)			