

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/03/2015
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NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF ANDERSON	STREET ADDRESS, CITY, STATE, ZIP CODE 2727 CROWNPOINTE CIR ANDERSON, IN 46012
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint #IN00179940.</p> <p>Complaint # IN00179940 - Substantiated. State deficiencies related to the allegations are cited at R0243 and R0247.</p> <p>Survey Dates: September 3, 2015</p> <p>Facility Number: 012129 Provider Number: 012129 AIM number: N/A</p> <p>Sample: 3</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p> <p>QR completed by 11474 on 9/9/15.</p>	R 0000		
R 0243 Bldg. 00	<p>410 IAC 16.2-5-4(e)(3) Health Services - Deficiency</p> <p>(3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:</p> <p>(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.</p> <p>Based on interview and record review, the facility failed to provide a procedure</p>	R 0243	For the residents found to be affected by the deficient practice	10/01/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>to accurately document the administration of resident medications for 3 of 3 residents reviewed for medication administration (Resident B, Resident C and Resident D). This deficient practice has the potential to effect 53 of the 53 residents currently living in the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The clinical record for Resident B was reviewed on 9/3/15 at 9:45 a.m. Diagnoses for the resident included, but were not limited to, hypertension, dementia with behavioral disturbance, asthma and fibromyalgia. <p>Review of the April, May and June 2015 Medication Reminder Documentation sheets for Resident B indicated the time, date and initials of the QMA (Qualified Medication Aide). Resident B's medication times were 9:00 a.m. and 11:00 p.m. The Medication Reminder Documentation sheets were located in each resident's locked medication box. No medications were listed to document what was given on the specific dates and times.</p> <ol style="list-style-type: none"> The clinical record for Resident C was reviewed on 9/3/15 at 9:58 a.m.. Diagnoses for the resident included, but 		<p>and all other residents with the potential to be affected the facility will have medication administration records (MARS) printed by Pharmakon Pharmacy. The MARS will have dates, residents name, name of medications, time of administration, dosage, and a place for staff administrating medication to initial and sign. The MARS will be printed and sent to the facility on or before the 27th of each month. Nursing staff will check all information, update any information that has been changed and return to pharmacy to be updated. The MARS will be kept in two binders one for each unit. Nursing staff will be in-serviced on how to document on the medication administration record sheets. To ensure the deficient practice does not recur a new order sheet will be initiated by the nurse each time a resident is seen by a physician or when the nurse receives an updated order. The new order check list will include: resident name, physician name, new orders received, documented in nurse's note, fax order to pharmacy, place new order on chart, update rewrites and MARS, put note in communication log, make out PRN sheet if applicable, leave note for nurses about change, and add any future physicians visits to transportation log.</p>				

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	<p>were not limited to, osteoarthritis, delirium, Alzheimer's, dementia, anxiety disorder and depressive disorder.</p> <p>Review of the April, May and June 2015 Medication Reminder Documentation sheets for Resident C indicated the time, date and initials of the QMA. Resident C's medication times were 8:30 a.m., 9:00 a.m., 1:00 p.m., 6:00 p.m. and 10:00 p.m. The Medication Reminder Documentation sheets were located in each resident's locked medication box. No medications were listed to document what was given on the specific dates and times.</p> <p>3. The clinical record for Resident D was reviewed on 9/3/15 at 1:45 p.m. Diagnoses for the resident included, but were not limited to, atrial fibrillation/pacemaker, osteoporosis, aortic stenosis, hypertension and depression.</p> <p>Review of the April, May and June 2015 Medication Reminder Documentation sheets for Resident D indicated the time, date and initials of the QMA. Resident D's medication times were 8:00 a.m., 12:00 p.m. and 7:00 p.m. The Medication Reminder Documentation sheets were located in each resident's locked medication box. No medications</p>			

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R 0247 Bldg. 00	<p>were listed to document what was given on the specific dates and times.</p> <p>During an interview on 9/3/15 at 2:43 p.m., the Director of Nursing indicated the current procedure for documenting medication administration had always been in place. "We are looking at some of our current procedures and are working on changing some of them. We will be looking at this as well."</p> <p>This Residential tag relates to Complaint IN00179940.</p> <p>410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.</p> <p>Based on interview and record review, the facility failed to ensure residents received the correct dose of medication according to the current physician order for 1 of 3 residents reviewed for medication administration. (Resident B).</p> <p>Findings include:</p> <p>The clinical record for Resident B was reviewed on 9/3/15 at 9:45 a.m.</p>	R 0247	For the resident found to be affected by the deficient practice the medication error was caught on 07/28/15 and an order to decrease the dosage was faxed to the pharmacy. The physician has been notified and resident's medical record was updated. Resident will have a medication administration record sheet (MARS) sent from the pharmacy each month. For all other residents with the potential to be effected by the deficient	10/01/2015

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	<p>Diagnoses for the resident included, but were not limited to, hypertension, dementia with behavioral disturbance, asthma and fibromyalgia.</p> <p>Resident B had an order, dated 6/12/15, for Trilafon (antipsychotic medication) 8 mg to be taken by mouth twice daily. On 6/19/15, the physician decreased the Trilafon dose to 4 mg to be taken by mouth twice daily.</p> <p>Review of the nursing notes indicated the following: On 7/28/15 at 4:30 p.m.: "Returned from MD appt. N.O.[new order] DC[discontinue] remeron (antidepressant medication) et increase trilafon to 8 mg BID. [check mark] B/P [blood pressure] x [times] 7 days d/t [due to] B/P increase at office and fax results to N.P.[Nurse Practitioner] Pharmacy aware of N.O. Med list updated."</p> <p>On 8/1/15 at 11:45 a.m.: "Call from QMA (Qualified Medication Aide) [initials] 7/31/15 at 10:03 p.m. stating she gave res[resident] 8 mg of Trilafon instead of 4 mg. No adverse reactions noted at this time MD and family aware."</p> <p>On 8/3/15 at 9:05 a.m.: "Call to MD office at this time to notify them again of med error and to let them know trofalin</p>		<p>practice the nursing staff has matched medications stored in residents apartments with the medications listed on the most recent physician's orders, no other errors were found. The pharmacy will a print monthly MARS for all residents that require medication administration. To ensure the deficient practice does not recur a policy on transcribing physician's order has been put in place and the new order check off sheet will be initiated each time a new order is received or changed. The medication error report form has been updated to require the resident's primary physician's signature instead of the facility's medical director. If there are actual or potential detrimental effects from the medication error the nurse will follow up with a phone call to the resident's physician for instructions on how to treat resident for side effects. Nurse will note name of person they spoke with from physician's office in resident's medical record and request the order be faxed to the facility. To monitor the corrective actions the Health Services Director or designee will match medications listed on the MARS with medications received from pharmacy each time medications are delivered and monthly when the rewrites/MARS are received from pharmacy. When a new order check off sheet is used for</p>				

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	<p>[sic] never was changed to 4 mg BID [twice a day] from the pharmacy from 6/19/15 so res was taking 8 mg BID the whole time. Family also aware."</p> <p>Review of the medication list for 6/12/15 indicated Resident B had an order for Trilafon 8 mg po bid.</p> <p>Review of the medication list for 6/19/15 indicated Resident B had an order for Trilafon 4 mg po BID.</p> <p>Review of the medication list for 7/21/14 indicated Resident B had an order for Trilafon 4 mg po BID.</p> <p>Review of the medication list for 7/24/15 indicated Resident B had an order for Trilafon 4 mg po BID.</p> <p>Review of the medication list for 7/28/15 indicated Resident B had an order for Perphenazone (Trilafon) 8 mg po BID.</p> <p>On 7/30/15, Resident B was taken to the emergency room by her family. Review of the emergency room physician report indicated Resident B appeared overly medicated. Resident B displayed trouble thinking, walking and had a blood pressure of 177/112.</p> <p>During an interview on 9/3/15 at 10:44 a.m., the Director of Nursing (DON) indicated new orders were transcribed by herself or the nurse who covered for her on her days off. The orders were then</p>		<p>new orders it will be filed in a binder. The Health Services Director will use the check off sheets to audit the residents medical records to ensure the MARS and physician's orders were updated correctly. This process will be done weekly and will be ongoing.</p>	

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	<p>sent to pharmacy. She indicated the order for the 4mg Trilafon had not been sent to the pharmacy but did appear on the facility generated order sheets.</p> <p>During an interview on 9/3/15 at 3:04 p.m., the Nurse Practitioner for Resident B's physician indicated the office never received notification from the facility that the medication error had occurred. The Nurse Practitioner reviewed Resident B's office chart to confirm no notification had been received. "The daughter called, I never talked to the facility. I got a call on the 30th (7/30/15) from the daughter telling me the medication had not been decreased. I told [physician's name] so he could talk directly to the emergency room physician."</p> <p>During an interview on 9/3/15 at 1:34 p.m., Resident B's daughter indicated she spoke with the DON about the medication error. She indicated the DON told her the medication order change had not been ordered from the pharmacy.</p> <p>Review of a current undated policy titled "Notification of Changes" was provided by the DON on 9/31/15 at 3:30 p.m. It indicated the following: "Policy: This facility shall immediately inform the resident, consult with the resident;s physician, and if known, notify</p>			

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	<p>the resident's legal representative or an interested family member when there is: (1) an accident involving the resident that results in injury and has the potential for requiring physician intervention; ...Procedure: ...All "attempted" notification(s), as well as successful notification(s) of physician(s) and family member(s) must be recorded in the medical record."</p> <p>Review of a current undated policy titled "Medication Errors and Drug Reactions, Documentation of" indicated the following: "...Procedure: 1.) Medication errors and/or drug reactions must be reported to the physician and responsible party/family member when there are any actual or potential detrimental effects to the resident...."</p> <p>This Residential tag relates to Complaint IN00179940.</p>						