

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 02/02/2016
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NAME OF PROVIDER OR SUPPLIER TERRACE AT TOWNE CENTRE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7252 ARTHUR BLVD MERRILLVILLE, IN 46410
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00189742.</p> <p>Complaint IN00189742- Substantiated. State Residential deficiency related to the allegation was cited at R0241.</p> <p>Survey Dates: 02/02/16</p> <p>Facility number: 002392 Provider number: 002392 AIM number: N/A</p> <p>Census by bed type: Residential: 33 Total: 33</p> <p>Census Payor type: Other: 33 Total: 33</p> <p>Residential Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed by 26143, on February 7, 2016.</p>	R 0000	<p>Disclaimer: "This planof corrective is submitted as required under either or both state and federallaw. The submission of this plan of correction on (date) does not constitute anadmission of fault of liability to the government entity of any third party, onthe part of The Terrace at Towne Centre, as to the accuracy of the surveyors' findingsof the conclusions drawn therefrom. Submission of this plan of correction alsodoes not constitute an admission that the findings constitute a deficiency orthat the scope and severity regarding the deficiency cited are correctlyapplied. Any changes to the community's policies and proceduresshould beconsidered to be subsequent remedial measures as that concept is employed inrule 47 of the federal rules of evidence and any corresponding state rules ofcivil procedure should be inadmissible in any proceeding on that basis and thecommunity reserves the right to object to the admission of this statement ofdeficiency or the plan of correction under any other theory of law.</p>	
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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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R 0241 Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on observation, record review, and interview, the facility failed to ensure medications were administered as ordered by the residents' physicians for 3 of 5 residents reviewed for medication administration in a total sample of 5. (Resident #C, #D, and #E)</p> <p>Findings include:</p> <p>1. During an observation of a morning medication administration on 02/02/16 at 8:30 a.m., LPN #1 prepared Resident #E's medication, which included: aspirin 81 mg (milligrams), one tablet Multivitamin, one tablet escitalopram (anti-depressant) 10 mg,</p>	R 0241	<p>Thecommunity submits this plan of correction with the intention that it isinadmissible by any third party in any civil or criminal action against thecommunity or any employee, agent officer, director, attorney or shareholder ofthe community or affiliated companies"</p> <p>POC for Deficiency OIZN11 In regards to state surveyors exit meeting on February 2,2016, Executive Director, Director of Nursing and Clinical Nurse Liaison wereinformed of several medication errors that occurred while LPN#1 were passingmedications. LPN #1 was immediately removed from medication cart and suspendedpending investigation. LPN#1 attended an all staff in-service performed byInTouch Pharmaceuticals on February 4, 2016. LPN#1 was required to successfullycomplete a medication pass with InTouch Pharmacy Nurse Liaison on February 4,2016. LPN#1 was also required to successfully complete</p>	02/29/2016

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	<p>one tablet ferrous sulfate (iron) 325 mg, one tablet polyethylene glycol (laxative) 17 grams potassium chloride (supplement) 10 meq (milliequivalents), one dorzolamide 2% solution (glaucoma eye drops), one drop each eye travatan 0.004% (glaucoma eye drops), one drop each eye odansetron (nausea medication) 4 mg, one tablet sucralfate (stomach medication) 1 gram, one tablet ipratropim nasal spray (bronchodilator)</p> <p>LPN #1 indicated there were seven tablets in the medication cup prior to administering the medications to the resident.</p> <p>LPN #1 administered the medications, administered the nasal spray of one puff per nostril, then administered the dorzolamide eye drops and then immediately administered the travatan eye drops.</p> <p>During an interview after the administration of the medications, LPN #1 indicated the policy was to administer the eye drops right after the other ones were given.</p> <p>Resident #E's record was reviewed on</p>		<p>four other supervised medication passes before being permitted to pass medications independently. LPN#1 successfully met qualifications by February 8, 2016. LPN#1 must also successfully complete one monthly medication pass with In Touch Pharmacy and one with Director of Nursing or designee for six months. Director of Nursing and or designee will audit practice monthly for six months. In Touch Pharmacy will also perform random medication pass audits with nursing staff at The Terrace for six months. The corrective action(s) that has been accomplished for Resident #E was physician was contacted and eye drop order was clarified to instruct staff to allow five minute period between administrations. All residents Medication Administration Records were reviewed. All residents with physician's orders for more than one eye drop will be clarified to read: allow five minute period between eye drop administrations. The facility recognizes that all clients have the potential to be affected by deficient practice. All staff educated on company's policy for proper administration of eye drops. LPN#1 was educated one on one by Director of Nursing in regards to company policy for eye drop administration. Audits will be conducted monthly per Physicians Recapulation Orders</p>	

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	<p>02/02/16 at 10:15 a.m. The resident's diagnoses included, but were not limited to, coronary artery disease, diabetes mellitus, depression, hypertension, and history of pneumonia.</p> <p>The Medication Administration Record (MAR), dated 02/2016, indicated: The amiodarone 200 mg, 1/2 tablet had not been given, there were initials with a circle around the initials. The escitalopram indicated the medication was scheduled for 9 p.m. and had not been given. The fluticasone spray, 50 mcg, 2 puffs each nostril had been given. The furosemide 20 mg daily had been given. The sucralfate 1 gram had been given at 7 a.m.</p> <p>The Physician's Recapitulation Orders, dated 02/2016, included the following orders: Amiodarone (heart medication) 200 mg, take 1/2 tablet daily, scheduled in the morning escitalopram 10 mg at bedtime fluticasone spray (steroid spray), 50 mcg (micrograms), inhale two puffs in each nostril furosemide (diuretic) 20 mg daily, scheduled in the morning sucralfate 1 gram by mouth, three times</p>		<p>by Clinical Nurse Liaison/ Medical Records to ensure that all residents with multiple eye drop orders will have additional instructions in body of order instructing staff to allow five minute period between administrations of eye drops. The corrective action(s) that has been accomplished for Resident #D was to educate all staff nurses and qualified medication assistants via a Proper Medication Administration In-Service instructed by In Touch Pharmaceutical that included lecture and post-test providing education on proper administration of oral medications, inhalers, eye drops and nasal sprays which was held February 4, 2016. All staff and qualified medication assistants were educated via staff communication that stated: "When administering any medications to a resident, patient must be in sight view/ eye-sight at all times. Nurse or QMA is not permitted to turn your back during medication administration. All nursing staff and qualified medication assistants were educated via staff communication on February 3, 2016 that stated that Director of Nursing and/or Clinical Nurse Liaison must be notified in the event that a resident's medication is depleted. Staff has also been instructed to obtain any</p>	

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	<p>daily, 7 a.m., 1 p.m., and 5 p.m.</p> <p>A Professional Resource, titled, "Nursing 2013 Drug Handbook", identified as a resource for the Nurses' at the facility by the Director of Nursing (DoN), indicated on page 756, the Ipratropium spray was a bronchodilator and on page 614, the fluticasone was a corticosteroid.</p> <p>During an interview on 02/02/16 at 12:17 p.m., LPN #1 indicated the escitalopram was scheduled to be given at bedtime. She indicated the resident was out of the amiodarone so the medication had not been given. She indicated the amiodarone was in the Emergency Drug Kit (EDK) and should have been given from there until the medication arrived from the Pharmacy. She indicated the sucralfate had also been given at 7 a.m. LPN #1 indicated she was not aware Ipratropium was not a substitute medication for fluticasone. LPN #1 also indicated, after reading the facility policy, the eye drops should have been given five minutes apart.</p> <p>During an interview on 02/02/16 at 12:35 p.m., Pharmacist #2 indicated Ipratropium could not be a substitute for fluticasone spray. She indicated the Ipratropium and fluticasone were not interchangeable.</p>		<p>medicationthat is needed from the facility's Emergency Drug Kit. Educational also postedin each Medication Administration Binder. Residents Medication Administration Recordwill be audited weekly for six months by Clinical Nurse Liaison and/or designee. Systemic changes will occur by 2/15/2016. It was also noted thatLPN#1 administered incorrect nasal medication to Resident #D. Facility recognizes that all residents have the potential to be affected by deficient practice. Oneon One educational counseling was performed by Director of Nursing to educateLPN#1 in regards to following seven rights of proper medication administration.All staff communication was derived to educate all staff nurses and qualifiedmedication administration assistants to seven rights of medicationadministration. All nursing staff and qualified medication administrationassistants must review seven rights and sign acknowledgement of understandingeach month for six months. Director of Nursing and/or designee will auditcompliance monthly for six months. Systemic changes will occur by February 20,2016. LPN#1 received on-on-one educational counseling in regardsto proper inhaler administration on February 3,</p>	

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	<p>During an interview on 02/02/16 at 12:51 p.m., the DoN indicated amiodarone was in the EDK and the nurse should have given the medication from the EDK.</p> <p>An undated facility policy, received from the DoN as current on 02/02/16 at 11:09 a.m., titled, "Eye Drop Administration Procedure for Adults", indicated, "...When two or more different eye drops must be administered at the same time, allow a 5-minute period between each."</p> <p>2. During a medication pass observation on 02/02/16 at 9:04 a.m., Resident #D had returned to her room after eating breakfast. LPN #1 prepared Resident #D's morning medications. The first medication removed from a pill bottle was atrovastatin (cholesterol medication) 20 mg. The label indicated the medication was to be given in the evening. LPN #1 was stopped from preparing the other medications. LPN #1 read the MAR again and indicated the medication should be given at bedtime and replaced the medication back into the pill bottle.</p> <p>LPN #1 continued to prepare other morning medications for the resident, which included: multivitamin, one tablet</p>		<p>2015 by Director of Nursing. The facility recognizes that all residents have the potential of being affected by deficient practice of not instructing resident to rinse mouth and spit after receiving inhaled medication. Staff communication informational notice and proper inhaled administration policy was presented to all staff nurses and qualified medication assistants to review and sign acknowledging understanding of policy. All residents' medication administration records reviewed and order will be clarified to instruct administrator of medication to instruct resident to rinse and spit if manufacturer directions instructs so. All residents' physician recapulation orders will be audited monthly by clinical nurse liaison and/or designee to clarify such instructions. This audit will be performed for six months. System changes will take place by February 20, 2016. Resident #C was immediately assessed upon notification of medication error in regards to Ropinirole not given with meals as physician order instructed. Physician and family notified immediately. Orders clarified per physician order to read: Ropinirole 2mg, one tab PO QID, Give with meals if nausea occurs. Facility recognizes that all residents have the potential to be affected by deficient practice. Director of Nursing and Clinical</p>				

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	<p>garlic tablet, one tablet metoprolol (blood pressure) 25 mg, 1/2 tablet metformin (blood sugar medication), one tablet nateglinide (blood sugar medication), 60 mg, 1/2 of a 120 mg tablet ranexa (heart medication), 500 mg, one tablet flovent inhaler (steroid), one puff fish oil 1200 mg, one tablet</p> <p>LPN #1 administered the oral medications. LPN #1 handed the inhaler to the resident, then turned away from the resident. Resident #D took one puff from the inhaler then attempted to give self another puff. LPN #1 turned around and assisted the resident with the inhaler as the resident was administered a second puff from the inhaler. LPN #1 indicated, after the inhaler administration, she had not realized the resident had already taken a puff of the inhaler. LPN #1 left the room and returned to the Medication Cart.</p> <p>Resident #D's record was reviewed on 02/02/16 at 10:31 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, hypertension, and asthma.</p> <p>The MAR and Physician's Recapitulation</p>		<p>Nurse Liaison met with InTouch Pharmacy on February 4, 2016 to discuss clarifying all residents' medication times to reflect patient centered care. On February 11, 2016 Director of Nursing spoke with Cris Lilly per InTouch Pharmaceutic technician to further discuss patient centered medication administration. On February 3, 2016 Director of Nursing communicated with Medical Director Dr. Chirag Patel to collaboratively implement patient centered medication administration times. All residents and/or residents' power of attorneys/guardian will be contacted to discuss medication administration times. Upon all involved parties approval, systemic changes will occur by February 29, 2016. Patient centered medication administration times will be audited per physician recapitulation orders monthly for twelve months by Director of Nursing and/or designee.</p>				

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	<p>Orders, dated 02/2016 indicated: aspirin 325 mg daily (not given) atorvastatin 20 mg at bedtime metoprolol 25 mg, take one tablet daily metformin 500 mg, take two tablets by mouth with meals nateglinide 60 mg, three times daily before meals flovent inhaler, 110 mcg (microgram), one puff twice a day</p> <p>During an interview on 02/02/16 at 11:07 a.m., LPN #1 indicated Resident #D had received a half tablet of metoprolol 25 mg. LPN #1 acknowledged the resident should have received a full tablet.</p> <p>During an interview on 02/02/16 at 12:17 p.m., LPN #1 indicated the aspirin had not been given because the resident was out of the medication and the family were to bring in the aspirin. LPN #1 indicated she did not have the resident rinse her mouth out after the inhaler was used. LPN #1 indicated the resident had already eaten breakfast before the medications had been administered.</p> <p>During an interview on 02/02/16 at 1:20 p.m., the DoN indicated the aspirin was available in the EDK and the medication should have been taken out of the EDK.</p> <p>A Professional Resource, titled, "Nursing</p>			

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	<p>2013 Drug Handbook", identified as a resource for the Nurses' at the facility by the Director of Nursing (DoN), indicated on page 616, indicated to instruct the patient to rinse mouth and spit water after using the flovent inhaler.</p> <p>3. During an observation of the breakfast meal on 02/02/16 at 8:30 a.m., Resident #C was sitting in the dining room eating breakfast.</p> <p>During an observation of a morning medication pass on 02/02/16 at 10:07 a.m., LPN #1 prepared Resident #C's medication, which included, ropinirole (Parkinson's medication) 2 mg, one and administered the morning medications to Resident #C.</p> <p>The MAR and Physician's Recapitulation Orders, dated 02/2016, indicated ropinirole (Parkinson's medication) 2 mg, one tablet four times a day with meals and nightly. The medication was scheduled for 8 a.m.</p> <p>During an interview after the medications were administered, LPN #1 indicated the ropinirole should have been given with meals.</p> <p>This Residential Tag relates to complaint IN00189742.</p>			

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

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