

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 07/18/2012
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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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R0000	<p>This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00111073.</p> <p>Complaint IN00111073- Substantiated. State deficiencies related to the allegations are cited at R006, R029, R052, R119, and R241.</p> <p>Survey dates: July 17-18, 2012</p> <p>Facility number: 004168 Provider number: 004168 AIM number: N/A</p> <p>Survey team: Honey Kuhn, RN, TC Deb Kammeyer, RN Carol Miller, RN Shelly Vice, RN</p> <p>Census bed type: Residential: 37</p> <p>Census payor type: Other: 37</p> <p>Sample: 7</p> <p>These deficiencies are cited in accordance with 410 IAC 16.2.</p>	R0000		

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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	Quality review completed on July 24, 2012 by Bev Faulkner, RN			

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R0006	<p>410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident:</p> <p>(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring.</p> <p>Based on record review and interviews, the facility failed to discharge a resident who required comprehensive nursing care oversight related to 38 known falls between 08/09/11 and 06/25/12. This deficiency effected 1 of 3 residents in a sample of 7 who were reviewed for falls. (Resident #25)</p> <p>Findings include:</p> <p>The record of Resident #25 was reviewed on 07/19/12 at 8:30 a.m. Resident #25 was identified, upon entrance to the</p>	R0006	<p>1. The facility was aware that Resident #25 is one who has fallen often. Frequent reminders were given to the resident to use his call button for assistance prior to ambulating as he became less steady on his feet. Facility requested help from the family to remove unnecessary furniture that provided more opportunity for falls. Physical therapy was offered and refused.</p> <p>A Shared Risk Agreement was offered in March of 2012 as a notice that the resident was taking on a known risk of potential for injury due to frequent</p>	08/01/2012			

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	<p>facility on 07/18/12, to be at an ECF (Extended Care Facility), following a fall with injury.</p> <p>Resident #25 was admitted to the facility in 09/2010 with diagnoses including, but not limited to: atrial fibrillation (irregular heartbeat), cardiomegaly, hypertension, and peripheral neuropathy. An admission service plan, titled, "ASSESSMENT TOOL FOR LEVEL OF SUPPORT", dated 09/22/10, indicated: "MOBILITY: AMBULATION: Is independently mobile with or without aids. Needs to rest at distances of more than 100 feet....Level II" "MOBILITY: TRANSFER...Independent"</p> <p>Review of an "ASSISTANT PLAN: Change of condition," dated 08/15/11, indicated: "Mobility: Assistive devices: wheel chair, cane and walker." "Transfer: Independent, stand-by assist, Requires assist of 1: d/t (due/to rt (right) arm fx (fracture) unable to bear wt (weight) on arm. Transport distance in w/c (wheelchair)."</p> <p>Review of the most recent "ASSISTANT PLAN: Change of condition," dated 06/08/12, indicated: "Mobility: Assistive devices. Wheelchair."</p>		<p>falls and failure to use his call button for assistance. The resident and family members felt that the resident's quality of life was still better in his assisted living apartment than the more limited independence that he would experience in a skilled care setting. No physician recommendation was given suggesting that comprehensive nursing care was needed.</p> <p>"Comprehensive nursing care" is defined in Indiana Administrative Code 410 IAC 16.2-1.1-15 Sec. 15 and states, "Comprehensive nursing care includes, but is not limited to, the following: (1) Intravenous feedings. (2) Enteral feeding. (3) Nasopharyngeal and tracheostomy aspiration. (4) Insertion and sterile irrigation and replacement of suprapubic catheters. (5) Application of dressings to wounds that: (A) require use of sterile techniques, packing, or irrigation; or (B) are infected or otherwise complicated. (6) Treatment of Stages 2, 3, and 4 pressure ulcers or other widespread skin disorders. (7) Heat treatments that have been specifically ordered by a physician as part of active treatment and require observation by nurses to adequately evaluate the process.</p>				

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	<p>"Transfer: Use gait belt, Requires assist of 1. Unable to use walker effectively, self propels." The "Cognitive" area indicated the resident's status as "moderate" for decision making.</p> <p>Review of a Physicians Office Visit report, dated 08/18/11, indicated in reference to the 1st fall with injury: "History of Present Illness: 1. right elbow fracture...Trauma occurred due to fall...He is also experiencing decreased mobility, tenderness and weakness....Sched (sic) for right elbow surgery ..." "Diagnostics History: 08/09/11 X-Ray elbow 2V (view) (R): displaced (R) olecranon [elbow] fx."</p> <p>Review of "Incident/Accident Report Forms", contained in the record, indicated another 11 of the 37 falls resulted in injuries:</p> <p>A nurse and the family were notified of each fall with injury.</p> <p>"10/09/11 (3:30 a.m. resident stated) WHAT HAPPENED: Resident stated he was going to the bathroom, when he stood up to clean himself, he fell forward. DESCRIBE INJURY: complain (sic) of (L) (left) shoulder pain, (L) knee has skin tear & (and) a little pain." No documentation to indicate physician</p>		<p>(8) Initial phases of a regimen involving administration of medical gases.</p> <p>At the time of the surveyors' presence, Resident #25 had been transferred from the hospital to a skilled care setting to recuperate after his last fall. Family continued to hold his apartment for a possible return due to the resident's desire to return, until 7/30/12 when they agreed to a facility discharge from Assisted Living due to surveyors' interpretation of resident's need for twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight.</p> <p>2. All residents within our assisted living facility are evaluated weekly by an interdisciplinary Resident Review Team. Recommendations for interventions appropriate to residents' needs are offered, including therapy referrals when falls occur. Determination is made regarding appropriate levels of support, offering more support as residents' needs dictate. Seven discharges to comprehensive nursing care took place thus far in 2012 when this review process determined that resident needs had progressed beyond the scope of our licensed residential care.</p>				

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	<p>notification, being seen by the physician, or sent to the ACF (Acute Care Facility: hospital), or notification of the Administrator.</p> <p>"11/16/11 7:00 a.m. WHAT HAPPENED: Res (resident) said he fell asleep in the chair in the bathroom and fell off the chair. DESCRIBE INJURY: (R) (right) knee abrasion, bruise on right shoulder, bruise to right elbow" Documentation indicated not necessary to notify physician, be seen by physician, not sent to ACF, and Administrator not notified.</p> <p>"11/19/11 4:00 p.m. WHAT HAPPENED: Res stated that he tripped on his table while he was going to put popcorn in microwave. DESCRIBE INJURY: has a scrape on hi upper back right side" Documentation indicated not necessary to notify physician, be seen by physician, not sent to ACF, and Administrator not notified.</p> <p>"01/26/12 3:15 a.m. WHAT HAPPENED: N. A. (non applicable). DESCRIBE INJURY: resident had opened a previous bruise and was bleeding" Documentation indicated not necessary to</p>		<p>3. Weekly review of residents will continue to occur. Family meetings will be conducted to review resident needs for additional support, up to and including discharge to comprehensive care. Assistance Plans will be updated every six months or more often as resident needs dictate.</p> <p>4. The Administrator is ultimately responsible to ensure that appropriate support is available to all residents living at Waterford Crossing. As such, he attends the weekly Resident Review meetings and works closely with Director of Nursing Services to ensure we are able to meet resident needs within the assisted living regulatory guidelines.</p> <p>5. Completion date: August 1, 2012</p>				

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	<p>notify physician, be seen by physician, was not sent to ACF, and Administrator was not notified.</p> <p>"02/07/12 3:15 p.m. WHAT HAPPENED: Resident stated that he was sitting on his walker went to try to get up so he can used (sic) the bathroom and he fell in the shower. DESCRIBE INJURY: Resident stated that his middle back hurt's (sic)" Documentation indicated not necessary to notify physician, be seen by physician, was not sent to ACF, and Administrator was not notified.</p> <p>"02/10/12 9:26 a.m. WHAT HAPPENED: Res stated he was getting his glasses & just fell. DESCRIBE INJURY: (L) middle toe, (R) middle toe, skin tears on (R) & (L) knees" Documentation indicated the physician was notified and saw the resident on 02/10 /12 at 2:30 p.m. The resident was not sent to an ACF and the Administrator was not notified.</p> <p>"03/08/12 12:10 a.m. WHAT HAPPENED: Res paged. Res was on edge of bed. Res said went to BR (bathroom), lost balance & 'sat' down hard on edge of stool. Res at first told RA (Resident Assistant) res fell.... DESCRIBE INJURY: sore right hip"</p>			

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	<p>Documentation indicated it was not necessary to notify the physician, be seen by physician, and resident was not sent to ACF. The Administrator was notified on 03/12/12.</p> <p>"03/20/12 time unknown; discovered 11:10 a.m. WHAT HAPPENED: was on stool & wanted to get up & fell. Couldn't push his call button. DESCRIBE INJURY: bruise on (R) side of forehead & hip (R) hurting" Documentation indicated it was not necessary to notify the physician, be seen by the physician, and the resident was not sent to an ACF. The Administrator was notified on an unknown date and time.</p> <p>"05/01/12 6:26 p.m. WHAT HAPPENED: Resident stated that he fell walking to his chair. DESCRIBE INJURY: skin burns on his left arm & ribs were really hurting him" Documentation indicated it was not necessary to notify the physician or for the resident to be seen by the physician. The documentation further indicated, the Administrator was not notified and the resident was taken to an ACF on 05/01/12 at 6:40 p.m. An entry on the back side of the form indicated: "05/01/12: Resident returned from ER (emergency room) c (with) fx to left</p>						

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	<p>ribs...."</p> <p>"05/09/12 3:00 a.m. WHAT HAPPENED: Res trying to transfer from chair to standing position fell to knees. DESCRIBE INJURY: res has small abrasion to left knee" Documentation indicated it was not necessary to notify the physician, be seen by the physician, or be taken to an ACF. The document did not address if the Administrator was notified.</p> <p>"06/25/12 11:15 p.m. WHAT HAPPENED: Res tried to stand up and walk to bathroom and fell between walker & recliner. DESCRIBE INJURY: c/o (complained of) left shoulder pain, open area on left knee" Documentation indicated it was not necessary to notify the physician or be seen by the physician. The resident was taken to an ACF on 06/26/12 at 12:15 a.m.. The document did not address if the Administrator was notified.</p> <p>Further review of the record indicated a "SHARED RISK AGREEMENT", dated 03/10/12 and signed by the resident's POA and the DNS (Director Nursing Services): re Resident #25 "has a risk of falls as a result of unsteady gait/does 0 (not) push call button for assist. I/we are</p>						

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	<p>also aware that Waterford Crossing Apartments provides assisted living and may not be able to prevent falls and the resident may experience the consequence of physical injury, head trauma, or death."</p> <p>The DNS (Director Nursing Services) was interviewed on 07/19/12 at 9:00 a.m. The DNS indicated Resident #25 had incurred numerous falls because "he doesn't use his call button". The DNS was queried in regards to injuries from falls and indicated the Resident #25 had fractured ribs, elbow, and humerus within the past year. The DNS was queried as to Resident #25 needing more care than the facility could provide and indicated "it is his home."</p> <p>The Administrator was interviewed on 07/19/12 at 9:45 a.m., in regards to the care needs of Resident #25. The Administrator indicated the family does not chose to move the resident and if the resident were placed in an ECF, "he would sit in a wheelchair with an alarm all day." The Administrator indicated the family had signed a SHARED RISK AGREEMENT and met the criteria of their facility's policy on Assisted Living.</p> <p>A review of the "Assisted Living Policy;; Residency Requirements for Assisted Living:05/2008", provided by the</p>						

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	<p>Administrator on 07/18/12 at 10:00 a.m., indicated: "Policy Statement...</p> <p>2. The prospective resident or resident(s): ... c. must be independently mobile (assistive devices may be used)... d. must be able to transfer independently...and must be able to transfer with the assistance of one person. e. must be able to manage his/her activities of daily living independently... j. must not be a safety risk to self or others....</p> <p>4. If a prospective resident or a current resident has difficulty with one or more of the above criteria, an assistance plan to meet his/her needs, will be developed...If resident or family refuses to accept the level of support needed, there resident will be given notice of need to find alternate living arrangement...."</p> <p>This Residential tag relates to Complaint #IN00111073.</p>			

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R0029	<p>410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency (d) Residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality.</p> <p>Based on record reviews and interviews, the facility failed to treat a resident with dignity and respect as evidenced by shaving the beard of a resident of the Amish-Mennonite faith without the prior consent, resulting in Resident #25 being embarrassed and not wanting to socialize. This deficiency effected 1 of 1 residents reviewed for care needs reviewed in a sample of 7. (Resident #25)</p> <p>Finding includes:</p> <p>The record of Resident #25 was reviewed on 07/19/12 at 8:30 a.m. Resident #25 was admitted to the facility 09/2010 with diagnoses including, but not limited to, chronic atrial fibrillation, cardiomegaly, hypertension, and peripheral neuropathy. The resident was on a LOA (leave of absence) from the facility following a fall and fracture.</p> <p>The Adm (Administrator) was interviewed on 07/19/12 at 10:30 a.m., in regards to an incident related to the shaving of the beard of Resident #25. The Adm. confirmed the occurrence and indicated the incident was investigated.</p>	R0029	<p>1. As reported to the surveyor, the CNA self-reported to the Administrator on the day of the incident that she had mistakenly shaved off a small beard and sideburns of Resident #25 when giving him a shower that morning. This was the first time she had assisted him with shaving and he and she did not communicate clearly during the shaving process. The resident stated, "I am disappointed" when he saw himself in the mirror after being shaved. At that point he expressed that he did not want his beard taken off.</p> <p>An investigation ensued, conducted by the Administrator. The concern in particular was that this resident did wear a beard in connection with his religious and cultural identity. The Administrator conducted disciplinary counseling with the CNA on 6/28/12 at 12:45 p.m. and recorded, "On 6/25/12 you provided ADL care for (Resident #25) and in so doing, you shaved off his beard, one that he has worn for many years. This beard is part of his religious identity and he was offended when he saw himself in the mirror without his beard."</p>	08/01/2012			

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	<p>The Adm. indicated RA #5 (Resident Assistant: CNA Certified Nursing Assistant) had assisted the resident following a shower during the week of 06/17/12. The Adm. indicated RA #5 self-reported she had shaved the beard of Resident #25 while providing care and he became distraught afterwards. The Adm. indicated RA #5 was aware Resident #25 was bearded since admission to the facility.</p> <p>Review of the record indicated no documentation in regards to Resident #25's beard being shaved off. A confidential interview with a resident acquaintance, during the survey, indicated Resident #25 was embarrassed and distraught following an incident when his beard was shaved and did not want to socialize following the incident. The interviewee indicated Resident #25's beard was shaved while being assisted in personal care at the facility.</p> <p>Review of a facility policy, "ASSISTED LIVING: Resident Rights, 05/2008", provided on 07/18/12 at 11:00 a.m. by the Administrator, indicated:...</p> <p>"Policy Statement: Residents do not leave their individual personalities or basic human rights being when they move to Waterford Crossing....</p> <p>1. be treated with dignity and respect.</p>		<p>"Sensitivity to a resident's religious and cultural preferences and beliefs are an important part of our RESPECT values."</p> <p>"Correction Action: 1. Written letter of apology to (Resident #25) and family by 6/29/12. 2. Cultural sensitivity education to be provided by your supervisor."</p> <p>The CNA accepted the corrective action and wrote a letter of apology (surveyor given copy of corrective action and letter). The letter of apology was delivered and read to Resident #25 by the Administrator on 6/29/12 at the comprehensive care facility he was currently at. The resident stated, "I forgive (CNA)—it was my fault too."</p> <p>The CNA attended an all-staff mandatory training in-service on 7/17/12 on special needs of the elderly which focused exclusively on understanding and respecting the religious and cultural beliefs of each resident's upbringing and background.</p> <p>2. All residents have the right to be treated with consideration, respect, and recognition of their dignity and individuality. No residents have been identified that have expressed concern about their cultural or religious beliefs being disrespected. The</p>				

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	<p>12. be free of physical, verbal, fiduciary or psychological abuse from staff, family, and other residents. "</p> <p>This Residential tag relates to Complaint #IN00111073.</p>		<p>weekly interdisciplinary Resident Review Team reviews each resident weekly to determine if there are emotional, mental, social, spiritual and/or physical issues that warrant additional support.</p> <p>3. Waterford Crossing's new-hire orientation includes review of Resident Rights and abuse prevention. Annually, mandatory training is conducted on resident rights and abuse prevention. Disciplinary action is initiated when resident rights have been violated and/or abuse has occurred. In accordance with Indiana Administrative Code 410 IAC 16.2-1.1-25 Waterford Crossing seeks to promote exercising of resident rights as defined in Sec. 25: "Exercising rights means that the residents have autonomy and choice to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement."</p> <p>4. Ongoing monitoring of resident well-being is gauged by daily interaction with residents in many different settings. The Administrator conducts resident satisfaction surveys, alternating each year between a written survey and 1:1 resident/administrator visits to assess their satisfaction and/or</p>				

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			<p>concerns. An open relationship is encouraged between residents and staff with opportunities extended to residents to give formal and informal feedback. The Administrator is ultimately responsible to ensure that residents feel respected and protected.</p> <p>5. Completion date: August 1, 2012</p>	

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R0119	<p>410 IAC 16.2-5-1.4(d)(1)(A-E)(2)(A-D)(3- Personnel - Noncompliance</p> <p>(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following:</p> <p>(1) Instructions on the needs of the specialized populations:</p> <p>(A) aged;</p> <p>(B) developmentally disabled;</p> <p>(C) mentally ill;</p> <p>(D) dementia; or</p> <p>(E) children;</p> <p>served in the facility.</p> <p>(2) A review of the facility's policy manual and applicable procedures, including:</p> <p>(A) organization chart;</p> <p>(B) personnel policies;</p> <p>(C) appearance and grooming policies for employees; and</p> <p>(D) residents' rights.</p> <p>(3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures.</p> <p>(4) Review of ethical considerations and confidentiality in resident care and records.</p> <p>(5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care.</p> <p>(6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.</p> <p>Based on record review and interview, the facility failed to ensure an employee who had previously been terminated from the facility's employment received orientation when rehired.</p>	R0119	1. The facility was not aware that the rehiring of a three-year employee, RA #5, seven months after termination warranted the same steps as the hiring of a first-time employee. RA #5 was	08/01/2012			

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	<p>Finding includes:</p> <p>The employee file of RA #5 (Resident Assistant: CNA: Certified Nursing Assistant) was reviewed on 07/19/12 at 9:00 a.m.</p> <p>RA #5's original DOH (Date of Hire) was 07/15/2008. RA #5 was terminated from employment on 09/15/2011 and rehired on 04/11/12. Review of the record indicated RA #5 did not participate in orientation, including but not limited to, Abuse, Resident Rights, and duties specific to resident care.</p> <p>The Business Office Manager (BOM) was interviewed on 07/19/12 at 9:30 a.m. The BOM indicated the facility had opted to pull archived records from the previous employee file of RA #5. The file included a "MEMO", dated 04/11/12, which indicated:...</p> <p>"Original hire 7/15/2008 Terminated on 9/15/2011 Rehired on 4/11/2012</p> <p>Some of the original paperwork was pulled from the closed file to set up the new employee file (application, training tool, etc) since the rehire happened within 1 year. Some forms were updated while</p>		<p>scheduled for and completed all day orientation with other newly hired employees on July 27, 2012. 2. All residents benefit from all staff being well oriented to mandatory training aspects and departmental training specific to their job. All staff includes those who may have worked in our facility in the past and are rehired at a later time. They will participate in needed orientation in order to be as effective and knowledgeable as possible as they re-enter the employee group. 3. The facility is now aware that rehired employees are to receive reorientation to ensure that they are as prepared as possible to resume job duties in the context of service to our residents. 4. The Business Manager will monitor all hiring and will ensure that all staff (first-time and rehired) complete the required mandatory orientation. This will be documented in each employee's personnel file. 5. Completion date: 8/1/12</p>				

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	<p>others had to be generated as new (tax and payroll forms etc.)"</p> <p>The Administrator was interviewed on 07/19/12 at 9:45 a.m. The Administrator indicated the RA #5 was terminated from employment due to attendance issues, not care issues. The Administrator indicated RA #5 had shaved the beard of a resident known to be of the Amish-Mennonite faith causing the resident to be distraught.</p> <p>This Residential tag relates to Complaint IN00111073.</p>						

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R0241	<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 record review and interviews, the facility failed to ensure PRN (medications as needed) medications were administered by a Licensed Nurse or QMA (Qualified Medication Aide) for 2 of 7 residents reviewed for medications in a sample of 7.</p> <p>Findings include:</p> <p>1. The record of Resident #1 was reviewed on 07/18/12 at 1:00 p.m. The resident was admitted to the facility on 11/16/10 with diagnoses including, but not limited to, CAD (coronary artery disease), glaucoma, diabetes, and Parkinson's disease.</p> <p>Review of "DAILY HAPPENING NOTES", indicated: "04/18/12 9:30 p.m. Resident paged (and) was complaining of pain in finger. RA (Resident Assistant) called NOC (Nurse on call) & was told to give resident two pain pills. Resident only wanted one, so their [sic] RA gave one."</p>	R0241	<p>1. Samples cited in this survey finding relate to non-licensed staff helping our residents self-medicate or self-administrate their PRN medications. The rule cited in this finding, "Medication shall be <i>administered</i> by licensed nursing personnel or qualified medication aides"—does not apply to the samples cited due to our understanding of the difference between "administration of" and "assistance with" medications.</p> <p>According to Indiana Administrative Code 410 IAC 16.2-1.1-4 Sec. 4: "Administration of medications means preparation and/or distribution of prescribed medications. This does not include reminders, cues, and/or opening of medication containers or assistance with eye drops, when requested by a resident."</p> <p>Safe medication management is a mutual goal between us as a facility and ISDH. Our pharmacy prepares the weekly medication needs of our residents. Our</p>	08/01/2012			

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	<p>(RA signature)</p> <p>2. The record of Resident #37 was reviewed on 07/18/12 at 1:30 p.m. Resident #37 was admitted to the facility on 01/18/11 with diagnoses including, but not limited to, dementia, depression, and anxiety.</p> <p>Review of "DAILY HAPPENING NOTES", indicated: "02/10/12 6:30 Resident complaint of headache. This RA called NOC and advised to assist with (1) Tylenol. (RA signature)"</p> <p>"02/10/12 8:15 Resident called and said she need (sic) a (sic) anxiety med (medication) called NOC advised to assist with (1) pill. (RA signature)"</p> <p>"02/13/12 12:43 a.m. Resident paged and complained of pain in her legs & was asking for PRN (take as needed) meds. Writer called NOC & she oked (sic) it. Writer assisted resident with PRN. (RA signature)"</p> <p>"02/18/12 1:04 p.m. Res called for 2 pain pills for ear ache. (unable to decipher) notified & will check res in 1 hr (hour) to see how pain is. (RA signature)"</p> <p>"02/21/12 8:01 a.m. Res wanted a blue &</p>		<p>nurses double check medications when they arrive and distribute them appropriately. The nurses administrate medications when needed. Our non-licensed C.N.A.s assist our residents with self-medication in accordance to physicians' orders and under the oversight of our nurses.</p> <p>R 0296 states, "The facility shall maintain clear written policies and procedures on medication assistance." Our licensed nurses and non-licensed C.N.A.s function within the boundaries of safe medication assistance based on clear and directive facility policies and procedures which are used to instruct non-licensed staff on safe medication assistance and appropriate documentation:</p> <p><i>Policy Title:</i> Assistance with Self Administration of Medication (Policy G-230)</p> <p><i>Purpose:</i></p> <ul style="list-style-type: none"> • To provide safe assistance with medications 				

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	<p>red pain pill for legs. Call nurse & nurse approved to assisted (sic) with PRN med. Will check (sic) in res late to see how pain is."</p> <p>"02/22/12 2:05 a.m. Resident paged and asked for PRN... Writer called NOC and she oked (sic) it. Writer assisted resident to PRN. (RA signature)"</p> <p>"02/22/12 11:45 a.m. Res requested a Tramadol because her joints were hurting. This R notified the nurse and the nurses said it was OK but she also had to take the anti-nausea pills so she wouldn't get sick to her stomach. (RA signature)"</p> <p>"02/25/12 1:45 a.m. Res called was having trouble sleeping....RA called NOC & was given OK to assist w (with) anti-anxiety meds. Told res RA will check back in one hr. (RA signature)"</p> <p>"03/04/12 2:00 p.m. Resident called & requested Tylenol. (Unable to decipher) said it was okay to assist w/2 pain pills for legs. Will check on later. (RA signature)"</p> <p>"03/05/12 11:15 p.m. Resident paged an (sic) requested 1 PRN pill. Writer contacted NOC an sic) NOC okeyed (sic) it. Writer will check resident within the hour. (RA signature)"</p>		<ul style="list-style-type: none"> • To provide guidance to the staff for what constitutes assistance with self administration • To provide consistency in the style of medication delivery system thus reducing confusion and errors <p><i>Policy:</i> Residents are expected to manage their own medications. Waterford Crossing's unlicensed staff do not prepare or distribute prescribed medications.</p> <p>Assistance with self administration is available and can include:</p> <ol style="list-style-type: none"> 1. Use of a weekly pill box planner, either from the preferred pharmacy or pill box planners filled and maintained by the resident or responsible party of the resident. 2. Reminding or cueing the resident at the time medications are to be taken, then resident takes pills by self. 3. Opening the pill box planner containing the pills for the time specified. 4. Assisting with eye drops when requested by the resident 5. Visual observation and recording of the resident taking the medications. <p>Assistance with self administration of medication means there is no decision regarding the preparation or distribution of medication on the part of the unlicensed staff.</p>				

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	<p>"03/06/12 9:00 a.m. Resident requested a pain pill call (sic) nurse she said it was okey (sic). RA assisted w/1 PRN pain pill & resident said that's all... 03/06/12 1:15 p.m. Resident requested an anti-anxiety pill. Call (sic) nurse she said OK. (RA signature)"</p> <p>The DNS (Director Nursing Services) was interviewed on 07/19/12 at 10:30 a.m. The DNS indicated all residents of the facility self administer medications. The DNS indicated the RA's only assist the residents by cueing on opening their pre-filled pill packets. The DNS indicated family members set up the medications for most of the residents. The DNS was queried as to PRN medications and indicated a small amount of each resident's PRN medications are kept in the resident's "pill planner" for RA's to cue the residents. The DNS indicated the RA's observe the resident's for side effects. The DNS indicated the facility does not utilize QMA's.</p> <p>The DNS was queried in regards to how the facility identifies the knowledge level of residents for administering their own medications. The DNS indicated they were assessed upon admission with the family present. The DNS was asked to provide a self-administration tool and indicated the tool used was the</p>		<p>Medication containers have been pre-filled in the weekly pillbox planners by a pharmacist and double checked by the staff nurse for accuracy; or pill box planners have been filled by a family member or responsible party. Each resident will be assessed by the nurse as to their ability to self administer medications. The resident's physician will also indicate the resident's ability to self administer with staff support. The amount and type of assistance needed will be defined in the resident's assistance plan. Level I support provides no assistance with medications whatsoever. Level II allows for reminders only. Level III, IV, V and VI allows for direct assistance of the staff for cueing, opening packets and observation for self medication. Any changes to the resident's drug regimen will be managed by the physician, nurse and pharmacist. The nurse will work with the pharmacist to adjust medication until new medications can be delivered by the pharmacy. Residents may choose to have any pharmacy deliver their medication if they manage medications with no assistance or medication set up is managed by the resident or responsible person according to State guidelines. Residents who need no assistance with their medication</p>				

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	<p>"ASSESSMENT TOOL FOR LEVEL OF SUPPORT" which is to be completed upon admission and consisted of the following:</p> <p>"Independent with Domestic Support: Independent. Knows names of meds being taken =1."</p> <p>"Assisted Living Basic: Independent. Knows names of meds being taken.=2"</p> <p>"Assisted Living ADL Assistance: Needs assistance with & observation of taking meds-gives self insulin. =3"</p> <p>"Assisted Living Mobility: Needs daily nursing assistance and observations of taking meds--gives own insulin with staff assist. =4"</p> <p>"Emily's House (dementia unit): Needs assistance with & observation of taking meds--staff gives insulin. =5"</p> <p>"Nursing Home Care: Requires IM/IV meds not manageable through home health/hospice. =6"</p> <p>The DNS indicated the ASSISTANCE PLANS are the form used to update. The form was reviewed with each resident chart and indicated a checklist determined by the nurse filling out the form. The facility had no tool to engage the resident and gauge the resident's actual knowledge of medications.</p> <p>The DNS indicated the RA's do "hand over hand" and can assist the resident's by</p>		<p>from staff but wish to utilize the weekly planner system established by Waterford Crossing, may do so.</p> <p>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. When a resident uses a PRN medication on a regular basis, the nurse will discuss with the resident's physician the possibility of making that medication routine rather than PRN and then it will be placed in the routine packets. If families choose to set up the pill box planners, they will be responsible to reorder medications when needed. If families choose to set up the pill box planners, they will be responsible to come to the resident's apartment and make any medication changes requested by the physician.</p> <p>Medication Intervention Intervention Defined Responsibility Self-management (Level 1) No staff involvement Resident/Family Reminders (Level 2) Verbal reminders given at scheduled med times Nurses and/or Certified Nursing Assistants</p> <p>Assistance (Level 3) Physical assistance to retrieve med</p>				

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	<p>tearing open the pill packs.</p> <p>The Administrator was interviewed on 07/19/12 at 11:00 a.m. The Administrator indicated the facility was within all guidelines of medication administration.</p> <p>Review of a facility policy, provided by the Administrator at the time, titled "Assisted Living: Assistance with Self Administration of Medication: 02/2011", indicated:</p> <p>"Policy: Residents are expected to manage their own medications....Assistance with self administration of medication means there is no decision regarding the preparation or distribution of medication on the part of the unlicensed staff. Medication containers have been pre-filled in multidose packages by a pharmacist and double checked by the staff nurse for accuracy; or pill box planners have been filled by a family member or responsible party.</p> <p>Each resident will be assessed by the nurse as to their ability to self administer medications....</p> <p>When a resident requests a PRN medication, the nurse or nurse on call must be contacted, ..."</p>		<p>box, and/or open box, and/or provide hand-over-hand assistance, and /or observe swallowing of medication.</p> <p>Nurses and/or Certified Nursing Assistants</p> <p>Administration (Levels 4-6) Mixing of and/or giving medication directly, and/or injecting, and/or placement of medication patch.</p> <p>Nurses</p> <p>Related Procedures</p> <ul style="list-style-type: none"> • Handling of Resident Medication • Medication Disposal • Medication Storage <p>State regulatory cross reference: Pharmaceutical services (410 IAC 16.2-5-6)</p> <p>Health services (410 IAC 16.2-5-4)</p> <p>Evaluation (410 IAC 16.2-5-2)</p> <p>Approval date 3/2005 Review date 2/2011 Review date Review date 11/2007</p>				

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	<p>"Medication Assistance:...</p> <p>2. Obtain medications from the designated container in the resident's apartment....</p> <p>c. Assist with the resident requested PRN medication.</p> <p>d. If the resident has several medication options and is not sure which one of their approved medications to request, the nurse or nurse on call will counsel the resident as to which medication to select and request the resident assistant to assist with...."</p> <p>This Residential tag relates to Complaint IN00111073.</p>		<p>Review date</p> <p>Review date</p> <p>Review date</p> <p>4/2008</p> <p>Review date</p> <p>Review date</p> <p>Review date</p> <p>5/2008</p> <p>Review date</p> <p>Review date</p> <p>Procedure:</p> <p>Handling of Resident Medication (Procedure G-240)</p> <p><i>Procedure:</i> 1. If Waterford Crossing staff is to assist with self administration of medication, medication must be in a pill box planner specifying the day, time, name of medication, dosage, and identification (color, shape), doctor's name, and script number.</p> <p>2. Standard medication times</p>	

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 07/18/2012
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>are morning (6-9:00 a.m.), noon (11 a.m.-12:00), evening (3-5 p.m.), and bedtime (6:30-8:00 p.m.)</p> <p>3. A one-week supply of meds will be provided at a time from the pharmacy or family or responsible party.</p> <p>4. The pill box planner will be kept in a designated container in each resident's apartment in a secure location.</p> <p>5. The pill box planner will be set-up by the pharmacist at the pharmacy under contract with Waterford Crossing or by family or responsible party, if so desired.</p> <p>6. Medications from the Waterford Crossing designated pharmacy for the next week will be delivered to the office on Tuesday and will be checked for accuracy by the staff nurse and will begin for the resident on Thursday.</p> <p>7. The nurse is responsible to place the next week's medications in the resident's container on Wednesday afternoon.</p> <p>8. The pharmacy will provide a medication list for the resident's chart. This sheet will be updated whenever there is a medication change.</p> <p>9. When there is a medication change, the pharmacy will send the new medication and the nurse will set-up the new medication until a new package is obtained from the pharmacy. If family or responsible party is handling</p>		

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			<p>medication, they will need to bring the new medication and place it in the pill box planners.</p> <p>Related Policy</p> <ul style="list-style-type: none"> Assistance with Self Administration of Medications <p>State regulatory cross reference: Pharmaceutical services (410 IAC 16.2-5-6) Health services (410 IAC 16.2-5-4)</p> <p>Evaluation (410 IAC 16.2-5-2) Approval date 3-2005 Review date _____</p> <p>Review date _____</p> <p>Review date 11/2007 Review date _____</p> <p>Review date _____</p> <p>Review date 4/2008 Review date _____</p> <p>Review date _____</p> <p>Review date 5/2008 Review date _____</p>	

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			<p>Review date</p> <p>Procedure Title: Medication Assistance (Procedure G-260)</p> <p>Procedure: 1. Remind the resident it is time to take their medications or respond to the resident's request for a specific PRN medication.</p>	