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 09/11/2012

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WATERFORD CROSSING APARTMENTS	1212 WATERFORD CIR GOSHEN, IN 46526

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R0000	This visit was for a Post Survey Revisit (PSR) to the State Licensure Survey and Investigation of Complaint IN00111073 completed on July 18, 2012. Complaint IN00111073-Not Corrected Survey dates: September 10, 11, 2012 Facility number: 004168 Provider number: 004168 AIM number: N/A Survey team: Ann Armey, RN Census bed type: Residential: 36 Total: 36 Census payor type: Other; 36 Total: 36 Sample: 7 These deficiencies are cited in accordance with 410 IAC 16.2. Quality review completed on September 18, 2012 by Bev Faulkner, RN	R0000		

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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R0241	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. A. Based on observation, interview and record review, the facility failed to follow physician's order regarding the administration of a medication to treat Parkinson's disease. This deficiency affected 1 of 3 resident's whose medication were reviewed in a sample of 3. (Resident #3) B. Based on observation, interview and record review, the facility failed to assure licensed nurses or QMAs (Qualified Medication Aides) administered medications to the residents. This deficiency affected 36 residents, who received assistance with their medication administration from CNA/RAs (Certified Nurse Aides/Resident Assistants). (Residents #1, #2,#3, #4, #5,#6,#7,#8, #9,#10, #11,#12, #13,#14,#15 #16,#17, #18, #19,#20,#21,#22,#23,#24, #25,#26, #27, #28, #29,#30,#31,#32,#33, #34,#35 and #36) Findings include:	R0241	R 241 A 1. Resident #3 was identified by the surveyor as having the incorrect dose of a Parkinson's medication. She pointed this out to the Personal Support Supervisor who immediately contacted the pharmacist who distributed the medication. The pharmacist acknowledged the error and correct dosage was provided the same day. A Medication Error Report was completed and physician and family were notified on the same day (9/10/12). A 12-hour caregiver was secured to ensure resident mobility would be supervised during awake hours. 2. All residents receiving medications are at risk for incorrect medications or incorrect dosage of medications. Residents receiving assistance with self administration are dependent on licensed staff to ensure that medications are given as prescribed by the physician. This starts with the nurse checking in all medications received from the pharmacy against the physician's	09/11/2012

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	A. The clinical record of Resident #3 was reviewed on 9/10/12 at 11:45 a.m., and indicated the resident was admitted to the facility on 4/4/09, with diagnoses which included but were not limited to, Parkinson's Disease. A physician's order, dated 7/23/12, indicated Resident #3 was to receive Mirapex (a medication used to treat symptoms of Parkinson's Disease) 0.5 mg., 1 1/2 tabs (0.75 mg), three times daily. The September 2012, POS (Physician Order Sheet) indicated Resident #3 was receiving Mirapex 1.5 mg three times daily. There was no documentation the 7/23/12, order for Mirapex had been discontinued or changed. On 9/10/12 at 2:00 p.m., Resident #3's medication box was observed with the Personal Support Supervisor. The list on the back of the pill box indicated the resident was receiving Mirapex 1.5 mg, three times daily (twice the ordered dosage). On 9/10/12 at 2:10 p.m., the Personal Support Supervisor was interviewed and indicated the pharmacist "misread" the		medication order and the pharmacy medication list. 3. The nurse responsible for checking in medications was instructed by the Personal Support Supervisor on 9/10/12 of the importance of verifying the incoming pharmacy medications with the most recent physician medication order, rather than assume that the pharmacy was error-free in distributing the medications. The new nurse verbalized an understanding of the importance of this critical step to reduce the possibilities of an error occurring in the future. 4. The Personal Support Supervisor will oversee the weekly medication check-in process weekly for one month and then spot-check once a month thereafter. Orientation for new nurses will emphasize all aspects of medication safety. 5. Completion date: 9/10/12 R 241 B. 1. Residents were reassessed for their ability to participate in self-administration of their medications. Those residents who are capable of self-administration with assistance will continue to receive assistance from C.N.A.s who received additional training on assisting residents with self-administration of medications on 10/30/12. A 3"x5" "script card" was created that will be attached to each weekly medication planner box to ensure that CNAs are	

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	original physician's order and as a result, Resident #3 had been given the wrong dose of Mirapex since 7/23/12. B. On 9/10/12 at 10:30 a.m., the Personal Support Supervisor was interviewed regarding staffing and indicated there was a licensed nurse and four CNAs (Certified Nursing Assistants) on the day shift, four CNAs on the evening shift and two CNAs on the night shift. The Personal Support Supervisor indicated the licensed nurse left at 3:30 p.m., and a licensed nurse was on-call during the evening and night. On 9/10/12 at 11:10 a.m., CNA (Certified Nursing Assistant) #10 was observed assisting Resident #22 and Resident #10 with their medication. On 9/10/12 at 4:15 p.m., CNA #11 was observed giving medication to Resident #26. During the observations, the following procedure was being followed by CNAs #10 and #11: The resident's medication boxes were obtained in the resident's rooms; A pre-filled pill box, with the resident's name, was taken from the medication box; The back of the pill box was reviewed, the resident's medications were listed and		receiving direction from the resident with each episode of medication assistance (see below). Assisting Resident with Self-Administration of Medication: 1. "(Resident's name), it's time to take your medicine, would you like me to assist you?" Wait for response. If "yes", hand pill planner to resident. 2. "It's (Tuesday morning), which would you like me to open?" 3. If resident points to correct tab, remove slot of meds & open tab directed by resident. 4. Give slot of meds to resident. 5. Resident pours pills out into dish or hand. Other: Can offer water, observe, document, etc. The residents who are not capable of successful self-administration with assistance were identified. These residents will receive all medication administration through licensed staff (nurses or QMAs). An experienced QMA was hired on 10/31/12 to provide identified residents with medication administration on the evening shift. 2. No negative resident outcomes were identified in regards to how our CNAs were assisting residents with their medications. However, due to the presence of some residents throughout our building who are unable to actively direct staff in medication assistance, the	

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	the number of pills to be taken, at the medication pass were counted; The lid on the pill box, for the day and time of the medication pass, was opened; The number of pills in the compartment were counted and were to correspond to the number of pills on the list; Water was given to the resident; The opened pill box was given to the resident and they took the medications. The residents did not make any comments or requests related to their medications. The clinical record of Resident #19 was reviewed on 9/10/12 at 2:30 p.m., and the resident was admitted to the facility, with diagnoses including but not limited to, dementia. The Assistance Plan, dated 7/27/12, indicated the resident's medication would be set-up by the pharmacy and she would receive assistance with the self administration of her medication. A Physician Order Sheet, dated 8/6/12, indicated Resident #19 had PRN orders for Tylenol with Codeine, (a medication used for the treatment of pain). Daily Happening Notes for Resident #19, signed by CNAs, indicated the following: On 8/25/12 at 7:25 a.m., the resident complained of "severe" back pain and the nurse was notified. "Instructed to assist Res (Resident) with 1 pain pill." On 8/30/12 at 8:15 a.m., the resident		facility is planning to utilize nurses and/or QMAs to assist all residents with their medications—thereby not needing to delineate the fine lines between "administration" and "assistance". Until QMA training is completed, however, the plan offered in Step 1 (above) will be in effect. 3. A QMA Class has been scheduled to begin November 6, 2012, with a certified trainer and will be held in our facility. Classes will be held three days a week. Eight well-qualified C.N.A.s, representing all three shifts, have been identified as candidates for this class. This training will be presented as a career-ladder opportunity and the cost for the class will be paid by the facility. Continuity of care of our residents will be maintained by utilizing existing staff who have the capacity for Q.M.A. training. Upon completion of successful training and testing, these Q.M.A.s will be worked into the schedule, assisting residents in the administration of medications. An experienced Q.M.A. was hired on 10/31/12. Upon completion of orientation, this Q.M.A., along with other licensed staff, will provide identified residents with medication administration on the evening shift. 4. The Executive Director will ensure that the Q.M.A. training proceeds as	

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	complained of "severe" back pain. "Nurse notified. Instructed to assist with 1 pain pill." On 9/4/12 at 1:15 a.m., the resident complained of lower back pain. "This writer assisted res. (resident) with a pain pill..." On 9/10/12 at 4:20 p.m., CNA #11 was interviewed regarding assisting residents with their PRN medications. CNA #11 indicated, if a resident asked for a PRN medication, she would call the nurse, and the nurse would tell them what to give the resident. CNA #11 indicated PRN medications were documented in the daily happening notes. The policy for Residency Requirements for Assisted Living, undated, provided by the Executive Director, was reviewed on 9/11/12 at 10:00 a.m., and indicated, "...The prospective resident or resident(s): ...h. must be able to self-administer medication. Reminders are available at Level II. Assistance with self-administration is available at level III,IV,V,and VI assisted-living support..." On 9/11/12 at 12:00 p.m., the Executive Director indicated the facility did not have a specific assessment to evaluate each resident's ability to safely self- administer their medications.		planned. The Personal Support Supervisor will schedule staff in such a way as to have availability of licensed staff to meet the medication assistance needs of our residents within their proper scope of practice and in accordance to applicable regulations. The Personal Support Supervisor will utilize the revised *Assistance with Resident Self-Administration of Medication Audit* form (attached) to ensure that CNAs are following the protocol that ensures resident-directed assistance of self-administration of medications. 5. Completion date: November 9, 2012	

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	The Executive Director indicated the assistance plan determined if the resident wanted medication set-up by the pharmacy and assistance with the self-administration of medications. On 9/11/12 at 12:30 p.m., the Executive Director provided a list of 36 residents, who received assistance from CNAs/RAs with their medication. The Executive Director indicated 16 of the 36 residents were unable to accurately choose or direct the self-administration of their medications because of cognitive impairments. The Medication Assistance Procedure, dated as reviewed on 8/2012, provided by the Executive Director, indicated: "1. Remind the resident it is time to take their medications or respond to the resident's request for a specific PRN medication. 2. Obtain medication from the designated container in the resident's apartment. a. If medications are in a pill box planner arranged by family or a responsible party, remind the resident of the day and time and ask if assistance is needed in opening the planner. b. If medications are in the weekly pill box planner from the pharmacy, double check the day and time and ask if assistance is needed in opening the			

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	planner. c. Assist with the resident's requested PRN medication. 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. 3. If resident requests, open the covering. 4. Provide glass of liquid for resident to take medication. 5. Document that resident took the scheduled medications at the prescribed time in the Assistance Record by initialing the appropriate date and time. 6. If the resident requests assistance and takes a PRN medication, document the time and then record the outcome of the PRN medication on the Daily Happening form. This state rule finding was cited on July 18, 2012. The facility failed to develop a systemic plan of correction to prevent recurrence. This state rule finding relates to Complaint IN00111073.			

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