

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 03/22/2012
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NAME OF PROVIDER OR SUPPLIER EMERALD HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 297 S 100 E WASHINGTON, IN 47501
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R0000	<p>This visit was for the Investigation of Complaint IN00105243.</p> <p>Complaint IN00105243 - Substantiated. State Residential finding related to the allegations is cited at R241.</p> <p>Survey date: 3/22/2012</p> <p>Facility number: 004904 Provider number: 004904 AIM : N/A</p> <p>Survey Team: Sharon Whiteman, RN TC Susan Worsham, RN</p> <p>Census bed type: Residential: 31 Total: 31</p> <p>Census Payor Type: Other: 31 Total: 31</p> <p>Sample: 03</p> <p>This state residential finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality review 3/26/12 by Suzanne Williams, RN</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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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 interview and record review, the facility failed to ensure nursing staff administered medications as prescribed by physician, related to failure to remove medication patches prior to applying a new patch, for 1 of 3 residents reviewed for medications in a sample of 3. (Resident A)</p> <p>Findings Include:</p> <p>Review of Resident A's clinical record on 03/22/12 at 9:40 a.m. indicated the following: The resident had diagnoses which included, but were not limited to, mild dementia, history of syncope (dizziness), and hypokalemia (low potassium level).</p> <p>A physician's re-write order for December, 2011 listed medications which included, but were not limited to, Exelon 9.5 mg/24 hr (milligrams every 24 hours) patch (Alzheimer medication) - Apply 1 patch topically once daily; Lidoderm patch 5 % (numbing pain medication) -</p>	R0241	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence,or any employees,agents,or other individuals who drafted or may be discussed in the response or Plan of Correction. In additions, preparation and submission of this Plan of Correction does Not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.We respectfully disagree with the below citation and would like to introduce for your review the attached documentation. This is provided for your review by the way of the Informal Dispute Resolution in effort to overturn the ruling.What corrective action(s) will be accomplished for those residnets found to have been affectedby this deficient practice? Resident A's clinical record was</p>	04/25/2012			

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	<p>Apply 1 patch topically every day; Lorazepam 1 mg (anti-anxiety medication) - Give 1 tablet daily at noon; and Hydrocodone-Apap 7.5-325 mg (pain medication) - Give 1 tablet twice daily at 8:00 a.m. and 7:00 p.m.</p> <p>Review of "Nursing Spectrum Drug Handbook 2010," indicated Exelon was used to treat mild to moderate dementia of Alzheimer's disease. Regarding dosage, the drug handbook indicated typical effective range is 6 to 12 mg/day, up to a maximum of 12 mg/day. The drug handbook indicated Exelon should be used cautiously in patients over 85 and could cause adverse reactions of dizziness, confusion, psychosis, and hallucinations. The drug handbook indicated, "Monitor patient's nutritional and hydration status, especially at start of therapy...Assess vital signs and cardiovascular status...Closely monitor cognitive status, particularly memory. Report significant decline or improvement."</p> <p>A "Global Deterioration Scale for Assessment of Primary Degenerative Dementia," dated 11/10/11, indicated Resident A had a moderate cognitive decline.</p> <p>A "Medication Record," for December</p>		<p>reviewed and found to be inconsistant with the findings from the survey conducted on 3/22/12.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?No other residents were found to be affected.What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not occur?The Residence Director, Wellness Director,and licensed staff were re-educated to our policy and procedure regarding adminsitration of the "Transdermal Patch Medication." The Wellness Director and licensed staff will be responsible for ensuring the Exelon patch has documented placement and removal.How will the corrective action(s) be monitored to ensure the deficient practice will not recur,i.e.,what quality assurance program will be put into place? The Wellness Director and/or Designee will perform a random weekly review of the Medication Administration Record for appropriate documentation and a random physical check of the residents to ensure patch removal. Findings will be reviewed during a scheduled Emerald House OA meeting at the end of the quarter to determine the need for the ongoing monitoring plan. Finding resulting in compliance will result</p>				

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	<p>2011 indicated the resident received an Exelon 9.5 milligram patch daily from 12/01/11 through 12/24/11. The Medication Record also indicated the resident received a Lidoderm patch daily from 12/01/11 through 12/24/11. The Medication Record indicated the Lidoderm patch was removed every day at 7:00 p.m. The Medication Record indicated on 12/22/11 the Exelon patch was placed on Resident A's left lower shoulder, on 12/23/11 the Exelon patch was placed on Resident A's right shoulder, and on 12/24/11 the Exelon patch was placed on Resident A's left shoulder.</p> <p>A resident services note, dated 12/12/11 at 7:00 a.m., indicated, "Resident sitting in chair by fireplace, she is yelling at staff and being hateful. Tried redirection and tried to get resident to come to dining room for coffee and she told me to 'go to he--.'" Yelling at other staff members to 'mind your own d-mn business.' Ativan 0.5 mg (1) po [by mouth] given at this time...."</p> <p>A resident services note, dated 12/13/11 at 11:00 a.m., indicated, "Spoke c [with] (Resident A's physician) about resident's behaviors. New order for Depakote 250 mg (seizure medication sometimes used to treat behaviors) (1) po Bid [twice</p>		in cessation of the monitoring plan.				

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	<p>daily]...."</p> <p>No further documentation was found in the resident services notes until 12/24/11 at 5:20 p.m.</p> <p>A resident services note, dated 12/24/11 at 5:20 p.m., indicated, "Resident (Resident A) not feeling well today. She did not want to stay in main area, wanted to go to room to lay down. Staff went to check on her and she was laying in bed unresponsive. White foamy sputum running outside of mouth. Rolled to side. [name of ambulance company] contacted and here to transport to ER. [name of family member] aware."</p> <p>A "Summary" from a local hospital indicated, "...Admission Date 12/24/11. The summary indicated Resident A's admitting and discharge diagnosis was "change in mental status." The summary indicated, "...Brief History and Hospital Course: ...(Resident A) apparently came into the hospital from nursing home as patient was having episode of unconsciousness and change in mental status. She was evaluated and kept in the hospital and patient clinically has improved some but she is having some agitation and psych problems because we stopped her psych medications and we were thinking the patient maybe having</p>						

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	<p>psych issues....Patient has been evaluated her (sic) on the medical floor and she has done well. Most of her labs and everything is (sic) negative....I will discharge her to (another floor) and she will be followed up on the psych floor...."</p> <p>A "History and Physical Examination" report, dated 12/24/11, indicated, "...History of present illness: ...(Resident A) apparently lives at Emerald House and she (Resident A) came into the emergency room as the patient had decreased mental status and was getting worse for the last few days. She lives at Emerald House and it seems like she was recently started on Depakote a couple of weeks ago and has been different since then. The patient also had some nausea and vomiting. Apparently the patient was lethargic in the emergency room. She was evaluated and kept in the hospital. The patient is unable to give major history, but she is a little bit more alert now....Physical Examination: Awake, alert, elderly female, confused, does not appear to be in distress. She is well-built...."</p> <p>Records provided by the local hospital, which Resident A was transferred to on 12/24/11, were reviewed on 03/22/12 at 12:00 p.m., and indicated the following:</p> <p>An "Emergency Department Nurses</p>						

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	<p>Notes" dated 12/24/11 at 6:20 p.m., indicated, "...CXR [chest x-ray] complete. Pt has 3 exelon (sic) patches on back. Ordered on med [medication] sheet as 1 dly [daily]. Removed 2 patches. Also had Lidoderm patch to (L) side. 6:30 p.m. Pt (Resident A's) family @ bedside...Pt coughing - sputum suctioned - airway clear....7:45 p.m. To ICU [Intensive Care Unit] per cart in stable condition."</p> <p>An "Emergency Physician Record," dated 12/24/11, indicated Resident A was admitted to the emergency room due to,"decreased responsiveness, new weakness, and decreased ability to stand/walk."</p> <p>A hospital "Consultation" report, dated 12/27/11, indicated, "...(Resident A) has recurrent episodes of irritability, agitation, yelling and cursing at the staff. She (Resident A) also has been restless, unable to sit still. She wants to walk unassisted and she is high risk for falling. Patient requires one-to-one to keep the patient safe....Mental Status Exam: ... (Resident A) had fair eye contact. Has difficulty with her hearing. Speech is slurred. She is stating that she is feeling fine. Affect is anxious and irritable. No hallucinations. No delusions, but she has paranoid ideation and delusional thinking. No suicidal or homicidal ideation. She is</p>						

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	<p>alert but disoriented about the place and person and date...."</p> <p>Interview with the Wellness Director on 03/22/12 at 11:10 a.m. indicated the facility policy was to chart by exception and if there were no changes in a resident's condition there would be nothing documented in the chart.</p> <p>Interview with the Wellness Director on 03/22/12 at 1:40 p.m. indicated she was not aware Resident A had three Exelon patches on until the resident's family told her. The Wellness Director indicated the hospital had sent the facility reports after the resident was discharged from the hospital, but the reports lacked documentation supporting Resident A having 3 Exelon patches on upon arrival to the hospital.</p> <p>Interview with LPN #1 on 03/22/12 at 1:42 p.m. indicated sometimes nursing staff charted on new medications and sometimes they didn't. LPN #1 indicated Resident A received a new Exelon patch daily and the previous patch was removed. LPN #1 indicated nursing really had to check the resident over carefully due to the resident removing her patches and putting them back in different places on her body. LPN #1 indicated she did not remember the resident having any</p>			

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	<p>adverse reactions to any of her medications and did not remember the day the resident was sent out to the hospital.</p> <p>Interview of the Wellness Director on 03/22/12 at 3:45 p.m. indicated Resident A was her usual "spunky" self right up until she was found non-responsive in her room.</p> <p>A "Transdermal Patch Medications" policy, dated June, 2008, was provided by the Administrator on 03/22/12. The policy indicated, "...TRANSDERMAL PATCH MEDICATION is prescription medication that is delivered through the skin and absorbed into the bloodstream in a time-released manner....Remove old patch, if applicable. This may still have some active ingredient, so leaving in place and applying a new patch would constitute a medication error (wrong dose), putting resident at risk for overdose. The used patch must be disposed of properly. Place the used controlled medication patch in sharps container, or per state guidelines or your nurse's instructions."</p> <p>This State Finding relates to Complaint IN00105243.</p>						