

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155487	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/30/2013
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NAME OF PROVIDER OR SUPPLIER BROWN COUNTY HEALTH AND LIVING COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 55 E WILLOW ST NASHVILLE, IN 47448
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: October 21, 22, 23, 24, 25, 28, 29, & 30, 2013</p> <p>Facility number: 000479 Provider number: 155487 AIM number: 100290880</p> <p>Survey team: Diana McDonald, RN-TC Cheryl Mabry, RN Susan Worsham, RN</p> <p>Census bed type: SNF: 8 SNF/NF: 99 Total: 107</p> <p>Census Payor type: Medicare: 12 Medicaid: 66 Other: 29 Total: 107</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on November 12, 2013; by Kimberly Perigo, RN.</p>	F000000	<p>This plan of correction is to serve as Brown County Health and Living Community's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Brown County Health and Living Community or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</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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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a physician's order was followed for acetaminophen (Tylenol) 1000 mg (milligram) daily, for 1 of 6 residents observed for medication administration. (Resident #89)</p> <p>Findings include:</p> <p>Resident #89's clinical record was reviewed on 10/29/13 at 11:55 a.m.</p> <p>Resident #89 diagnosis included, but not limited to abnormal gait, edema, osteoporosis, constipation, depressive disorder, dementia, anemia, and muscle weakness.</p> <p>A Brief Interview for Mental Status (BIMS) dated 7/29/13, which is a interview to evaluate if a resident is interviewable, with a score of 8-15 is considered interviewable. Resident #89's score was a 12, which indicated interviewable.</p>	F000282	<p>F282 483.20(k)(3)(11) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. Resident #89 received an accurate dose of acetaminophen (Tylenol) 1000 mg (milligram) during the survey process and thereafter.2. All residents receiving routine acetaminophen (Tylenol) have the potential to be affected.The community has conducted an audit of all residents receiving routine acetaminophen (Tylenol).No deficiencies were found. 3. The systemic change will include:Licensed nurses have been reeducated on the five steps of proper Medication Administration. Licensed nurses will complete a competency check for medication administration upon hire and annually. Education will be provided to licensed nurses regarding the systemic change. 4. Director of Nursing or designee will monitor a medication pass with one nurse on each unit, randomly over all three shifts, including the weekend nurse(s) weekly for 4 weeks, then monthly for a duration of 12 months of</p>	11/29/2013
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	<p>A careplan dated October 2013 indicated, "Resident has ST [short term] memory loss, modified independent decision making and usually understands spoken messages.</p> <p>Current October 2013 physician's order which indicated a start date of 12/3/2010 indicated, " ...Acetaminophen Extra Strength ... Tablet; 500 mg; ... 2 tablets; Oral ... Once A Day ... 08:00 AM."</p> <p>On 10/23/13 at 8:16 a.m., LPN #2 was observed during medication administration to take out 1 Tylenol 500 mg (milligram) tablet for Resident #89. LPN #2 had locked the medication cart and was preceding to take the morning medications to Resident #89. When LPN #2 was asked what the doctor's Tylenol order was, LPN #2 indicated, "2 pills for 1000 mg." When asked how many Tylenol's should be given, LPN #2 indicated, "2 pills." When asked how many total pills should be in the medication cup for Resident #89, LPN #2 indicated "10 [all morning medication]" should be given. LPN #2 counted the number of pills in cup and indicated that there were 9</p>		<p>monitoring. Any concerns will be addressed. The results of these reviews will be discussed at the monthly facility Quality Assurance Committee meeting monthly for 3 months and then quarterly for one year. Frequency and duration of reviews will be increased as needed, if compliance is below 100%. 5. Completion Date: November 29, 2013</p>		

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	<p>pills in the cup. LPN #2 indicated, "Oh I thought I had popped out 2 pills. There is only 1 Tylenol in the cup."</p> <p>On 10/30/13 at 10:45 a.m., observed pill count for Resident #89 by LPN #1, which indicated there were 33 Tylenol extra strength pills remaining for Resident #89 out of 60 pills that were delivered on 10/15/13. The label from the pharmacy on the pill box indicated, "30 of 60."</p> <p>Interview on 10/30/13 at 10:45 a.m., LPN #1 indicated Resident #89's Tylenol 500 mg was delivered on 10/15/13. "[Gender] should receive 1000 mg daily at 8:00 a.m. Two pills." When asked to count how many pills were left, LPN #1 indicated "32." When recounted LPN #1 indicated, "33 pills." When asked how many pills should be left, LPN #1 indicated "30." When asked what does this mean if 33 pills were left and this was the 15th day, LPN #1 indicated, "30 should be gone but only 27 pills were given and 3 are left. A dose and 1/2 was missing." Then LPN #1 indicated, "I guess this means 3 pills weren't given."</p> <p>Interview on 10/30/13 at 11:20 a.m., DON indicated Resident #89,</p>			

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	<p>"always knows how many pills she is getting and would never refuse her Tylenol. The last pharmacy review completed in June or July showed no discrepancy."</p> <p>On 10/30/13 at 11:43 a.m., DON indicated, "I just spoke with the pharmacist [pharmacist name] and [gender] indicated, "The single Acetaminophen 500 mg tablet for [resident's name] could possibly be explained by a number of scenarios, including that by the pharmacy overfilled by 1 tablet." Also received faxed letter on 10/30/13 at 11:41 a.m., from the DON from pharmacist. Review of documentation labeled "Customer Visit Report" received on 10/30/13 at 12:25 p.m., from the DON indicated " ... Med Pass Audit ... see below ... Comments : carts were in good shape. Scheduled complete check on 7/13/13. ..." The DON had not provided documentation to indicated resident refusal of Tylenol or overfill since review.</p> <p>Review of policy labeled "CYCLE FILL" on 10/30/13 at 11:11 a.m., received from the DON indicated, "...Medications are automatically reordered and dispensed by anniversary date of the original</p>				

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	<p>medication order. ... Cycle fill is utilized to facilitate an accurate Medicare Part D accountability of reorders of routine drugs. Procedure ... 2. A 30-day supply of medication is sent to the facility every 28 days as long as the medication will be dispensed for a 14 day supply."</p> <p>Review of documentation labeled "Administering Medications " received from the DON on 10/30/13 at 11:11 a.m., indicated "Policy Interpretation and Implementation ... 3. Medications must be administered in accordance with the orders ... , ... 6. The individual administering the medication must check the label to verify the right medication, right dosage, ... before giving the medication."</p> <p>3.1-35(g)(2)</p>			