

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 02/28/2013
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NAME OF PROVIDER OR SUPPLIER RIVERWALK COMMUNITIES LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 401 SE SIXTH ST EVANSVILLE, IN 47713
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R000000	<p>This visit was for the Investigation of Complaint IN00122224, Complaint IN00123847, and Complaint IN00124005.</p> <p>Complaint IN00122224 - Substantiated. State findings related to the allegations are cited at R2, R87, and R241.</p> <p>Complaint IN00123847 - Substantiated. State findings related to the allegations are cited at R241.</p> <p>Complaint IN00124005 - Substantiated. No findings related to the allegations are cited.</p> <p>Unrelated finding is cited.</p> <p>Survey dates: February 25, 26, and 28, 2013</p> <p>Facility number: 011274 Provider number: 011274 AIM number: N/A</p> <p>Survey team: Anne Marie Crays, RN TC Jodi Meyer, RN (February 25, 26)</p> <p>Census bed type: Residential: 94</p>	R000000		

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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	<p>Total: 94</p> <p>Census payor type: Medicaid: 79 Other: 15 Total: 94</p> <p>Sample: 13</p> <p>These state findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 7, 2013, by Jodi Meyer, RN</p>			

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R000002	<p>410 IAC 16.2-5-0.5(b) Scope of Residential Care - Offense (b) A residential care facility may not provide comprehensive nursing care except to the extent allowed under this rule.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident who was totally dependent on staff for her care was able to be transferred out of bed, for 1 of 6 residents reviewed for quality of care, in a sample of 13. Resident G</p> <p>Findings include:</p> <p>On 2/26/13 at 10:00 A.M., during confidential interview with Staff # 3, Staff # 3 indicated, "[Resident G] is totally dependent for care. We have to feed her, and she is incontinent. We don't have enough staff to do it." Staff # 3 indicated it would take 2 staff to transfer the resident, and since there was not enough staff, the resident "never gets up."</p> <p>On 2/26/13 at 11:35 A.M., Resident G was observed lying in bed, with her eyes open. No staff or personal sitter was observed with the resident.</p> <p>On 2/26/13 at 11:55 A.M., the clinical record of Resident G was reviewed. Diagnoses included, but were not limited to, combined mixed dementia.</p>	R000002	<p>R002</p> <p>It is the practice of Riverwalk to assure that all residents meet level of care for the facility.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident G has been reviewed. It is believed that this facility can care for this resident at this time. This resident is currently on hospice. The POA wishes for this resident at the present time to remain at the facility for end of life care. The resident is currently free of weight loss and pressure ulcers and is able to utilize call light if needing assistance. In addition, hospice services are receiving orders for resident to have therapy in an attempt to increase resident's strength. The POA is arranging for the resident to have a sitter for several hours a day. This resident is located directly across from the nurses' station where staff more intense monitoring can occur. The facility will continue to work with this resident/POA related to care and discharge planning if needed.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents have been reviewed to</p>	04/01/2013			

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	<p>A Physician's Report for Guardianship, dated 7/23/12, included: "...Dementia - generalized weakened physical status, does not socialize out of her room, increased confusion...Unable to make any safe decisions at this time, poor judgement...Requires 24 hour supervision due to physical [and] mental status...."</p> <p>The most recent Resident Evaluation for Residential Care/Service Plan, dated 11/21/12, indicated: "Mobility, Requires supervision or escort assistance. Transfer, Requires supervision, encouragement, or cueing. Eating, Requires supervision, encouragement, or cueing...Hygiene/Dressing, Requires some physical assistance. Toileting, Requires total assistance... Mental Status, Moderate Impairment...Medications, Requires complete supervision and administration of all meds...Pain, Moderate pain...."</p> <p>A nurse's notation, dated 11/21/12, indicated, "Resident is confused - in bed - is on Hospice care at this time - requires total care with bathing, dressing, grooming and all personal care - is incontinent of [bowels and bladder] - fed per staff...has a sitter during the day...is unable to voice her needs and wants to the staff - meds adm. [administered] per self."</p>		<p>assure that they meet level of care. No additional residents were identified.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>All nursing staff has been in-serviced related to assuring that residents requiring additional care are attended too more frequently. The in-service includes assuring that residents are assisted with transfers as needed. Nurses will be responsible for assuring that residents' needs are met on their designated shifts via rounds. In addition, the IDT team reviews all residents at least every 6 months or if a significant change of status would occur to assure that the resident's needs are being met by the facility.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>An audit tool will be utilized that will randomly review 5 residents. The tool will be completed monthly x3 and then quarterly x3. Any issues identified will be immediately addressed. The tool will be forwarded to the QA committee for review with any recommendation for change implemented.</p> <p>The date the systemic changes will be completed:</p>				

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	<p>A hospice Social Work note, dated 1/24/13, indicated, "...Asked to 'get out of this bed.' SW [social worker] spoke to RN [initials] about this...."</p> <p>A hospice nurses note, dated 1/31/13, indicated: "...Pt [patient] has been asking to 'get up and walk' over past few weeks. Needed much assist to get to sitting posn. [position] on side of bed and needed two to transfer. Knees buckled upon attempting to bear weight....enc [encouraged] [illegible] to get up to w/c [wheelchair] if she requests."</p> <p>A hospice Social Work note, dated 2/5/13, included, "...Additional Considerations (unsafe social/emotional environment, etc.), Spoke [with] Dghtr [sic] @ length...Dghtr. not concerned @ this time about level of care @ [name of facility]...."</p> <p>A hospice nurse's note, dated 2/14/13, included: "Bed Mobility, [Extensive Assistance] 1 Assist, Transfer [Total Dependence], 2 Assist, Dressing [Extensive Assistance] 1 Assist, Personal Hygiene [Total Dependence] 1 Assist...HA [health aide] Visit Frequency: 2 x 1 wk...Mental Status: Oriented to situation, person, place, confused/forgetful at times...asking to try</p>		4-1-13				

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	<p>to walk, SN [skilled nurse] enc. [encourage] to be up in w/c for short periods if tolerated and try walking...Stool: Incontinent...Urine: Incontinent...."</p> <p>On 2/26/13 at 2:15 P.M., Resident G was observed lying in bed, asleep. No staff or personal sitter was observed with the resident.</p> <p>On 2/26/13 at 2:15 P.M., during interview with LPN # 1, she indicated Resident G has a personal sitter "sometimes." LPN # 1 indicated the sitters were hired by the resident's family, and "we never know when they are coming."</p> <p>On 2/28/13 at 9:40 A.M., Resident G was observed lying in bed. CNA # 1 was observed changing an incontinent brief. CNA # 1 indicated the resident "was supposed to have someone sitting with her, but I don't know where they are." CNA # 1 indicated the resident was having frequent loose stools, and every time he cleaned her up, she would "ooze more." CNA # 1 indicated he was the only CNA working that day, but had 2 orientees working with him. CNA # 1 indicated the resident required total care.</p> <p>This state finding relates to Complaint IN00122224.</p>						

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R000035	<p>410 IAC 16.2-5-1.2(j)(1-7) Residents' Rights - Deficiency (j) Residents have the right to the following: (1) Participate in the development of his or her service plan and in any updates of that service plan. (2) Choose the attending physician and other providers of services, including arranging for on-site health care services unless contrary to facility policy. Any limitation on the resident ' s right to choose the attending physician or service provider, or both, shall be clearly stated in the admission agreement. Other providers of services, within the content of this subsection, may include home health care agencies, hospice care services, or hired individuals. (3) Have a pet of his or her choice, so long as the pet does not pose a health or safety risk to residents, staff, or visitors or a risk to property unless prohibited by facility policy. Any limitation on the resident ' s right to have a pet of his or her choice shall be clearly stated in the admission agreement. (4) Refuse any treatment or service, including medication. (5) Be informed of the medical consequences of a refusal under subdivision (4) and have such data recorded in his or her clinical record if treatment or medication is administered by the facility. (6) Be afforded confidentiality of treatment. (7) Participate or refuse to participate in experimental research. There must be written acknowledgement of informed consent prior to participation in research activities.</p> <p>Based on interview and record review, the facility failed to ensure a resident who</p>	R000035	R035 It is the practice of this facility to assure that service plans are revised appropriately when there	04/01/2013			

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	<p>exhibited aggressive behavior towards residents and staff had interventions in place to address the aggressive behavior, for 1 of 1 residents reviewed with aggressive behavior, in a sample of 13. Resident H</p> <p>Findings include:</p> <p>On 2/25/13 at 3:30 P.M., during confidential interview with Staff # 4, Staff # 4 indicated Resident H had several behaviors. Staff # 4 indicated the resident had been monitored "for several months," and that the staff had sent the resident to the emergency room different times, but "they just send him back." Staff # 4 indicated Resident H was a younger resident.</p> <p>On 2/26/13 at 2:20 P.M., during confidential interview with Staff # 5, Staff # 5 indicated several residents and staff are afraid of Resident H. Staff # 5 indicated, "He's dangerous when he drinks." Staff # 5 indicated the previous Director of Nursing had informed staff, "It's not okay if he smokes in his room, but it's okay if he drinks. That doesn't seem right."</p> <p>On 2/26/13 at 10:00 A.M., during confidential interview with Staff # 3, Staff # 3 indicated, "Last week he hit a</p>		<p>are changes related to resident care.</p> <p>The correction action taken for those residents found to be affected by the deficient practice include:</p> <p>Resident #H has been reviewed and the service plan updated.</p> <p>Other residents that have the potential to be affected have been identified by:</p> <p>All residents have been reviewed to assure that service plans accurately reflect resident care and behaviors</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</p> <p>It is the Director of Nursing, or designee, responsibility to update and revise the service plan as changes occur. The nurses have been in-serviced related to updating the service plans as changes related to the residents occur.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>An audit tool has been initiated that randomly reviews 5 residents related to the plan of care and reflection of the resident's current condition and updates with pertinent revisions. The Director of Nursing, or designee, will complete this tool monthly x3 and then quarterly x3. The tool will be reviewed through the QA process with changes based on the</p>				

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	<p>nurse. He has alot of behaviors. He gets drunk and belligerent. He is feared by the other residents."</p> <p>The clinical record of Resident H was reviewed on 2/28/13 at 10:20 A.M. Diagnoses included, but were not limited to, CVA and history of alcoholism.</p> <p>The most recent Resident Evaluation for Residential Care/Service Plan, dated 11/16/12, indicated: Mobility, Independent. Transfer, Independent...Mental Status, Mild Impairment...Behavior, Behavior managed by increased staff time, moderate more than three times per week. Exhibits inappropriate behavior, i.e., disrobes, takes others' belongings, wanders aimlessly. Verbally aggressive toward staff..."</p> <p>A nurse's notation, dated 11/16/12, indicated, "Up in w/c [wheelchair] - is able to transfer with stand by assist - alert - is aphasic from a CVA - assisted with bathing...he understands when spoken [sic] but doesn't always get all of the message conveyed - requires assistance with decision-making - has poor judgment - he has difficulty understanding the needs that must be met and is not always cooperative when given direction...."</p>		<p>committee's recommendations.</p> <p>The date the systemic changes will be completed: 4-1-13</p>				

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	<p>Nurses Notes included the following notations:</p> <p>1/2/13 at 3:30 P.M.: "Resident [up] at nurses station yelling [and] screaming stating 'F---k you, F---k you' tried to approach continued to yell then sped away in w/c to room - spoke [with] resident in rm [room], appeared to calm down."</p> <p>1/2/13 at 5:55 P.M.: "Resident in hallway yelling at another resident, standing up, swinging arms. Approached resident became aggressive [with] staff as well. Removed other resident taken to room. Continued to cuss at staff. [Physician] notified, sent to ER for evaluation."</p> <p>1/2/13 at 8:30 P.M.: "Dr. called stated he was from [psychiatric hospital] and had evaluated [Resident H]. He stated [Resident H] passed psych eval. [evaluation] but had a breathalyzer reading of 0.150 and was x 2 over limit for legally drunk. Stated he would send papers/med. forms back to the facility with the patient."</p> <p>1/2/13 at 9:15 P.M.: "Resident returned to facility. Smelled like alcohol and was laughing...."</p> <p>1/2/13 at 11:00 P.M.: "CNA found papers</p>						

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	<p>in resident's room RE: Hosp. ER visit. DX [diagnosis]: Alcohol intoxication... [No] new orders. To F/U [follow up] [with] PCP [primary care practionner] regarding frequent agitation."</p> <p>1/3/13 at 9:00 P.M.: "Resident again being loud [and] noisy. Refuses to waite [sic] wants to be first for everything. Becomes agitated and tried to bully other residents."</p> <p>2/7/13 at 5:00 P.M.: "Resident went to dinning [sic] room. He approached the serving area became verbally abusive towards staff...Resident became louder and yelled at staff...Resident stood up out of his wheelchair trying to become physical across dinning serving area. This nurse intervened...continued to be verbally aggressive towards staff. Resident went upstairs to his apartment. Resident smelt [sic] of alcohol. His speech was more slurred than normal. His eyes were red, and he could not sit up straight...Resident was sent to [name of hospital] ER for evaluation [and] treatment..."</p> <p>A facility transfer form, dated 2/7/13, indicated, "Reason for transfer/other information, Possible Alcohol intoxication. Aggressive behavior toward resident [and] staff. Possible drugs</p>			

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	<p>involved."</p> <p>2/7/13 at 9:00 P.M.: "Resident will be returning to the facility at this time."</p> <p>2/17/13 at 8:00 P.M.: "Resident started yelling, cursing, waving arms in air, because he didn't like the order in which this nurse was admin. [administering] meds to residents. Behaving in a threatening manner."</p> <p>On 2/28/13 at 2:30 P.M., during interview with the Administrator, she indicated she was preparing to issue Resident H a 30 day discharge notice.</p>			

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R000087	<p>410 IAC 16.2-5-1.3(b)(1-3) Administration and Management - Noncompliance (b) The licensee shall provide the number of staff as required to carry out all the functions of the facility, including the following: (1) Initial orientation of all employees. (2) A continuing inservice education and training program for all employees. (3) Provision of supervision for all employees.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient staff were scheduled to administer baths or showers, answer call lights timely, and respond to fire drills, for 3 of 4 residents interviewed regarding staff, and for 4 staff members interviewed. Residents D, E, and I. Staff # 3, # 4, Staff # 5, Staff # 6</p> <p>Findings include: On 2/25/13 at 9:10 A.M., during the initial tour, LPN # 2 indicated the staff working that day were herself, LPN # 1, QMA # 1, RN # 2, CNA # 1, CNA # 2, and CNA # 3. LPN # 1 indicated there were 4 floors which had residents living on them. LPN # 1 indicated, "There should be a CNA on each floor." On 2/25/13 at 9:20 A.M., during interview with Resident D, he indicated staff "were not giving me my showers."</p>	R000087	<p>R087 It is the practice of Riverwalk to assure that there adequate staff to meet the needs of the residents <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> Residents D and E are receiving showers according to schedule Resident I is receiving medications in a timely manner <i>Other residents that have the potential to be affected have been identified by:</i> All residents have been reviewed to assure that they are receiving services in accordance with their needs and that staff schedule appropriately. <i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i> The facility has hired and will continue to hire additional nursing staff until all positions are filled. The facility has also created a policy that if an employee tenders a resignation</p>	04/01/2013			

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	<p>Resident D indicated it had probably been "more than 1 month" since he had a shower. Resident D indicated, "No one comes when I pull my call light." Resident D appeared to be poorly groomed, with a dirty face and hair.</p> <p>On 2/25/13 at 10:40 A.M., the Administrator provided the facility's current census. The census indicated 94 residents resided in the facility.</p> <p>On 2/26/13 at 9:30 A.M., during confidential interview with Staff # 4, Staff # 4 indicated, "It's really frustrating. There's not enough help. The CNAs can't get their showers done. A CNA is off on vacation this week. But if a CNA is ever off sick or on vacation, it's crazy." Staff # 4 indicated staff were trying to work different shifts to help cover, but it wasn't helping. Staff # 4 indicated there was not a Director of Nursing there, and the Administrator was not answering her calls on evenings or weekends.</p> <p>On 2/26/13 at 10:00 A.M., during confidential interview with Staff # 3, Staff # 3 indicated on Sunday 2/24/13, there was 1 CNA working on day shift. That CNA had to take care of the residents on the 4 different floors. Staff # 3 indicated that was at least the fourth time recently where there had been only 1</p>		<p>that efforts to recruit will begin immediately. Human Resources have been in-serviced related to this policy. The facility has also created a new position called a "Resident Care Assistant" which will work to meet non-care needs of the residents thus allowing the CNA's to have more time for hand-on-care. The staffing pattern will be reviewed daily to assure that adequate staff is in the facility to meet the needs of the residents</p> <p>New shower sheets have been developed to include all resident's that require assistance with showers to assure that staff is assisting them as needed. The nursing staff has been in-serviced related to the new shower sheets</p> <p>The residents in this facility come to the nurses' station to receive their medications. The facility is opening a second nurse's station that will eliminate the wait time for medication administration. Nursing staff has been in-serviced related to the opening of the new nurses' stations. Notices have also gone to the residents related to the new station.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>The Director of Nursing, or designee will audit employee shift sheets weekly x3, then monthly x3.</p> <p>Shower sheets for 5 residents will</p>				

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	<p>CNA scheduled. Staff # 3 indicated there was frequently only 2 CNAs scheduled for day shift. Staff # 3 indicated showers and baths are not being done because there wasn't enough staff. Staff # 3 indicated 3-4 days a week, not all residents are receiving showers. Staff # 3 indicated, "The schedule is always short." Staff # 3 indicated one resident was totally dependent on staff, and was unable to be transferred out of bed due to lack of staff.</p> <p>On 2/26/13 at 2:20 P.M., during confidential interview with Staff # 5, Staff # 5 indicated, "We are so understaffed, it's awful." Staff # 5 indicated, "Think other places may pay more, but no one wants to work here." Staff # 5 indicated it was very hard to get every task accomplished.</p> <p>On 2/28/13 at 9:30 A.M., during confidential interview with Staff # 6, Staff # 6 indicated, "Staffing is a problem." Staff # 6 indicated there was 1 CNA working "all day Sunday [2/24]." Staff # 6 indicated attempts were made to contact the Administrator, since there was no longer a Director of Nursing, but the Administrator did not return the call until 5:30 P.M. that evening. Staff # 6 indicated baths were not being done. Staff # 6 indicated, "Sometimes there is only 1</p>		<p>also be audited weekly x3 then monthly x3 to assure residents needing assistance receive showers as scheduled. An audit of 5 residents will occur to assure that their medications are being administered timely. This audit will also take place weekly x3 then monthly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the audits at the scheduled meetings with recommendations as needed.</p> <p>The date the systemic changes will be completed: 4-1-13</p>				

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	<p>nurse and 1 CNA on evenings or nights for the whole building."</p> <p>On 2/28/13 at 9:20 A.M., during interview with Resident I, Resident I indicated he "was so tired of my medications being late." Resident I indicated he was supposed to receive his medications at 8:00 A.M., and he goes down from his 5th floor apartment to the 4th floor nursing station to receive them. Resident I indicated his medications are frequently late. Resident I indicated he tries not to ask the staff for help, because he "knows they are busy."</p> <p>On 2/28/13 at 9:20 A.M., during interview with Resident I, the facility fire alarm started sounding. At approximately that same time, the Administrator approached the surveyor, and indicated she "hoped it was a drill." An announcement over the intercom indicated the fire alarm was on the 3rd floor in the laundry room. The alarm continued to sound. The Administrator left the 5th floor. No staff was observed on the 5th floor during the fire alarm. At approximately 9:25 A.M., the Administrator returned to the 5th floor, and indicated the alarm was a drill. When questioned where the staff was on the 5th floor, the Administrator indicated the staff had all responded to the fire on the third</p>						

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	<p>floor.</p> <p>On 2/28/13 at 9:30 A.M., LPN # 3 indicated during a fire alarm, staff were to close resident doors, and move residents toward fire exits. LPN # 3 indicated she would think there should be a staff person on each floor. LPN # 3 indicated the staff working that day were 2 LPNs, 2 QMAs, 1 CNA, and 3 CNA orientees.</p> <p>On 2/28/13 at 9:45 A.M., during interview with Resident E, Resident E indicated the facility was "very understaffed." Resident E indicated the staff "do the best they can." Resident E indicated on one occasion she pushed her call light at 10:00 P.M., and someone responded at 1:00 A.M. Resident E indicated she tries to do as much as she can, because she knows the staff are busy. Resident E indicated her bed sheets had not been changed for over 2 weeks, so she finally asked a CNA if she could change them. Resident E indicated no one provides ice water for her, but she is able to "go down to the nursing station on the 4th floor and ask for it." Resident E indicated she frequently asked a family member to assist her with her showers, since staff were so busy. Resident E indicated she was supposed to receive a shower twice a week.</p>						

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	<p>On 2/28/13 at 10:05 A.M., the Activities Director provided Resident Council minutes for November and December 2012, and January 2013. Minutes, dated 12/27/12, included: "New Concerns, Showers not given on their scheduled days, Addressed [with] nursing...Staff need to check on residents when not in DR [dining room]. Addressed [with] nursing."</p> <p>On 2/28/13 at 1:30 P.M., during interview with the Administrator, she indicated she had recently terminated staff, and had just hired new staff.</p> <p>This state finding relates to Complaint IN00122224.</p>			

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R000241	<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 medications were administered as ordered by the physician, in that one resident received medications that had been previously discontinued [Resident B] and one resident received the incorrect dosage of a medication [Resident F], for 2 of 8 residents reviewed for medications, in a sample of 13. Residents B and F</p> <p>Findings include:</p> <p>1. On 2/25/13 at 11:30 A.M., during interview with Resident B's responsible party, he indicated he did not think Resident B was receiving the correct medications. He indicated he could tell when Resident B received some of the wrong medication, because "she sleeps a lot." He indicated he had informed the nurses, but the mistakes kept occurring.</p> <p>On 2/25/13 at 2:20 P.M., the clinical record of Resident B was reviewed.</p>	R000241	<p>R241 It is the practice of this facility to assure that residents receive medications in accordance with the physician's orders <i>The correction action taken for those residents found to be affected by the deficient practice include:</i> Resident #B physician was notified of the medication error. This resident's orders have been reviewed and the MAR now accurately reflects the physician's orders. Resident #F physician was notified of the medication error. This resident's orders have been reviewed and the MAR now accurately reflects the physician's orders <i>Other residents that have the potential to be affected have been identified by:</i> All residents physician's orders have been reviewed to assure that the MAR accurately reflects the physician's orders. <i>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:</i></p>	04/01/2013			

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	<p>A Service Plan, dated 7/26/12, indicated the resident did not self-administer medications.</p> <p>A Physician's order, dated 7/26/12, included, "Geodon [an anti-psychotic medication] 40 mg 1 capsule twice daily."</p> <p>A Physician's order, dated 9/4/12, indicated, "Depakote [a mood stabilizer] 500 mg two tablets by mouth once daily."</p> <p>On 10/2/12, during a physician's visit, documentation listed the resident's current medications. The list did not include Geodon or Depakote.</p> <p>Documentation indicated the resident was transferred to the emergency room on 12/2/12, and physician orders were received for "Naprosyn [an anti-inflammatory medication] 375 mg BID [twice daily] [with] meals x 30 doses." Additional physician orders indicated to discontinue Cymbalta [an anti-depressant] and Celebrex [an anti-inflammatory medication].</p> <p>A hospital Pain Center note, dated 1/3/13, indicated, "Please give only above meds to [Resident B]..." and listed Lortab [pain medication], Flexeril [muscle relaxer], Lasix [blood pressure medication],</p>		<p>The nursing staff has been in-serviced related properly transcribing a physician's order to the MAR and notifying pharmacy of any order changes. Please see below for monitoring through the QA process.</p> <p>The corrective action taken to monitor performance to assure compliance through quality assurance is:</p> <p>The Director of Nursing, or designee, will complete this audit monthly x3, and then quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the audits at the scheduled meetings with recommendations as needed.</p> <p>The date the systemic changes will be completed:</p> <p>4-1-13</p>	

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	<p>Klor-Con [potassium], Protonix [stomach acid], and Duragesic [pain medication]. The note did not include Cymbalta, Geodon, Depakote or Naprosyn.</p> <p>Medication Administration Records, dated December 2012, January 2013, and February 2013, indicated the resident continued to receive Cymbalta, Geodon, Depakote, and Naprosyn.</p> <p>No laboratory work regarding Depakote levels had been ordered or performed.</p> <p>On 2/28/13 at 10:35 A.M., Resident B's physician's office was contacted. RN # 1 indicated she was the office nurse. RN # 1 reviewed Resident B's current medications at the physician's office, and indicated the resident's current medications did not include Cymbalta, Depakote, Naprosyn, or Geodon.</p> <p>2. On 2/23/13 at 9:40 A.M., RN # 2 was observed during a medication pass to administer Metoprolol [blood pressure medication] 50 mg two 1/2 tablets to Resident F.</p> <p>The clinical record of Resident F was reviewed on 2/25/13 at 12:05 P.M.</p> <p>A Physician's order, dated 1/4/13, indicated "Metoprolol Tartrate 50 mg tab</p>						

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	<p>take one-half tablet by mouth once a day."</p> <p>The order was not documented on the current February 2013 recertification orders.</p> <p>On 2/25/13 at 12:15 P.M., during interview with RN # 2, he indicated he did not read the order correctly, and should have given only 1/2 instead of 2 tablets.</p> <p>3. On 2/28/13 at 2:00 P.M., the Administrator provided the current facility policy on medication administration, dated 11/2012. The policy included: "All medication is to be administered as prescribed...." The Administrator indicated at that time that the nurses on the floor complete and verify the recertification orders each month, and are responsible for transcribing new orders from office visits to the recertification orders.</p> <p>This state finding relates to Complaint IN00IN00122224 and Complaint IN00123847.</p>						

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