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 03/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITLOCK HOUSE	1719 S ELM ST CRAWFORDSVILLE, IN 47933

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R000000	This visit was for the Investigation of Complaint IN00124568. Complaint IN00124568 Substantiated, state residential deficiencies related to the allegation are cited at R0247. Survey date: March 4, 2013 Facility number: 004419 Provider number: N/A AIM number: N/A Survey team: Joyce Hofmann, RN Census bed type: Residential: 41 Total: 41 Census payor type: Other: 41 Total: 41 Sample: 4 These state residential findings are in accordance with 410 IAC 16.2. Quality Review completed on 03/07/2013 by Brenda Nunan, RN.	R000000		

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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R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to give a resident the prescribed dosage of a medication ordered by physician for 1 of 4 sampled residents reviewed for medication administration [Resident B]. Findings include: Resident B's clinical record review, on 03/04/13 at 11:35 a.m., indicated the resident had diagnoses which included, but were not limited to, bullous pimphigoid, scabies, cerebrovascular accident, arthritis, degenerative disc disease, neuropathy, seizures, peptic ulcer disease, cancer, arteriosclerotic heart disease, and anxiety. "Resident Services Notes", dated 08/22/12, indicated the resident was seen by a dermatologist for a follow-up visit for bullous pimphigoid [a skin condition]. The notes indicated, "...still on mtx [methotrexate (an anitneoplastic; antimetabolite,	R000247	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 addition, 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 or any conclusions set forth in this allegation by the survey agency. **Citation #1 R 247 410 IAC 16.2-5-4(e)(7) Health Services Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident B's records were reviewed for appropriate documentation of orders and found to have no inaccuracies. **How the facility will identify other residents having the potential to be affected by the same deficient**	03/31/2013

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	folic acid antagonist)] 15 (milligram)/week...." "Resident Services Notes," dated 09/20/12, indicated, "...Is stable...c [with] mtx 15/wk [week]...." A physician's "New Orders," dated 10/23/12, indicated, "...Continue methotrexate 15 mg [milligrams] po [by mouth] once weekly...." "PHYSICIAN FAX TRANSMISSION/PHONE ORDER," dated 10/31/12, indicated, "Increase methotrexate to 25 mg (10 tabs) po weekly." The phone order had not been signed/validated by the physician. "Resident Services Notes," dated 12/12/12, indicated, "...Follow up on bullous pimphigoid, controlled c [with] mtx 10 mg q [every] week, ...Cont. [Continue] mtx 10/wk...." The record did not indicate the facility contacted the physician for clarification of the medication dose. The Medication Administration Records [MARs], dated November and December 2012 and January and February 2013, indicated Resident B received Methotrexate 25 mg by mouth weekly.		**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 recur?** The WD was re-educated as to policy and procedure for recording new prescription orders on MARS and reviewing for accuracy. Orders received via phone will be faxed to the physician to be verified and signed. The Wellness Director has started a tickler file to ensure phone orders that are faxed are returned with signature timely. **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 review new orders for accuracy when making changes to the MAR. The Wellness Director and or Designee will review the faxed order log daily and make follow up calls to the physicians if signed orders have not been returned within 5 to 7 days. The RDQCM will review monthly for 4 months to ensure compliance. It is the responsibility of the Wellness Director and or Designee going forward to monitor the medication administration records and physician orders. The Wellness	

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	"Resident Services Notes," dated 03/01/13, indicated, "...was on high dose mtx...was d/c'd [discontinued]...." Interview with the Wellness Director on 03/04/13 at 11:55 a.m., indicated the methotrexate was started on 07/19/12 and continued at the same dose (15 mg/week) until 10/31/2012. The Wellness Director stated, "I missed it," when asked about the discrepancies in medication doses on the November and December, 2012 MARs, the January and February 2013 MARs, and the physician's note, dated 12/12/12. The Wellness Director indicated Resident B received Methotrexate 25 mg/week from 10/31/2012 thru 02/19/2013. Interview with the Wellness Director on 03/04/13 at 4 p.m., indicated the facility contacted the physician to obtain additional medication when the resident's supply was depleted. The Wellness Director indicated the physician's office staff contacted the facility and indicated the resident should have had an adequate supply of medication to last until the next scheduled medical appointment. The physician's staff indicated 25 mg/week was an incorrect dose.		Director and or Designee will conduct periodic review of medication records to ensure correct transcription and will review phone orders for physician signature in accordance with the above referenced regulation once the citation has been determined to be in compliance with Whitlock House's internal QA process. **By what date will the systemic changes be completed?** March 31, 2013	

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	Interview with the Wellness Director, on 03/04/13 at 4:30 p.m., indicated she forgot to fax the phone order, dated 10/31/12 for physician verification of order and signature. Review of the facility's policy on "Phone Order", dated 01/2006, indicated, "...Phone Orders. Physician Telephone Order forms are used to document in writing orders phoned in to the residence by a resident's physician. Written and/or faxed orders are highly preferred over phone or verbal orders and should be requested whenever possible...Send the top copy of the physician's order to the physician for signature, along with a self-addressed stamped envelope to facilitate an efficient return of the order form and a note asking the physician to sign and return the order...If the telephone order has not been signed by the physician and returned to the residence within five to seven days, call the physician's office and document the follow-up. A tracking system should be used to ensure that appropriate follow-up occurs on a weekly basis until the order has been signed and returned." Review of the facility's policy on			

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	"MEDICATION ERRORS," dated 07/2009, indicated, "...If a medication error occurs, NOTIFY THE WELLNESS DIRECTOR AND/OR RESIDENCE DIRECTOR IMMEDIATELY AND FOLLOW HIS/HER DIRECTIONS...Some situations also require the completion of an Incident Report form...The completed Incident Report must be reviewed and signed by the Wellness Director and Residence Director, with a plan formulated to prevent recurrence of the incident...Documentation regarding the initial incident (as well as follow-up documentation by the Wellness Director and/or Residence Director) should be made in the Resident Service Notes...Provide appropriate follow-up training with the staff person who made the medication error to ensure that a re-occurrence does not occur. Document all action taken in the employee's Personnel Notes...." Review of the facility's policy on Documentation Requirements, dated 07/2009, indicated, "...Each month, before placing the new MAR/TAR [Medication Administration Record/Treatment Administration Record] in the MARs [sic] binder, the newly printed MAR/TAR should be			

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	reviewed by the Wellness Director to ensure that all items listed are correct and have incorporated any changes in orders that occurred during the current month. Make any necessary changes to the contract pharmacy so the corrections can be made for the next month's record...." Review of the facility's policy on ADMINISTRATION OF MEDICATIONS/TREATMENTS, dated 07/2009, indicated, "...Medications and treatments are administered to residents as determined by review of their medication status, and in accordance with physician order, and state laws and regulations...." This state residential finding is related to Complaint IN00124568.			