

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 05/04/2015
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NAME OF PROVIDER OR SUPPLIER HEARTH AT TUDOR GARDENS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 11755 N MICHIGAN RD ZIONSVILLE, IN 46077
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R 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00171525.</p> <p>Complaint IN00171525 - Substantiated. State residential deficiencies related to the allegations are cited at R090, R241, and R297.</p> <p>Survey date: April 29, 30, & May 4, 2015</p> <p>Facility number: 012263 Provider Number: 012263 Aim Number: N/A</p> <p>Census bed type: Residential: 87 Total: 87</p> <p>Census by payor type: Other: 87 Total: 87</p> <p>Sample: 7</p> <p>These state findings are cited in accordance with 410 IAC 16.2-5.</p>	R 000	The statements made in this Plan of Correction are not an admission to, nor does it constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state regulations, the community has taken or is planning to take the actions set forth in the following Plan of Correction. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
R 090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency			

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>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:</p> <p>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:</p> <p>(A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents.</p> <p>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.</p> <p>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.</p> <p>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.</p> <p>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:</p> <p>(A) employee's full name; and (B) dates and hours worked during the past twelve (12) months.</p> <p>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a</p>			

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	<p>notice posted of their availability.</p> <p>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request</p> <p>Based on interview and record review, the facility failed report an unusual occurrence to the State agency within 24 hours of awareness of an allegation of a missing narcotic pain medication and/or failed to identify and report when a narcotic pain medication was documented in the medical record as unavailable after it was delivered by the pharmacy for 2 of 7 residents reviewed for unusual occurrences (Resident V and Resident T).</p> <p>Findings include:</p> <p>1. Resident V's record was reviewed on 4/30/15 at 1:40 p.m. The record indicated Resident V had diagnoses which included after care and rehab post orthopedic procedure and severe pain.</p> <p>An untimed assessment, dated 4/24/15, indicated Resident V's judgement and memory were "good."</p> <p>During an interview on 5/4/15 at 10:00 a.m., the Executive Director (ED) indicated Resident V reported on 4/16/15 to the Director of Assisted Living (AL)</p>	R 090	<p>R 090 Administration – reporting of unusual occurrences</p> <p>1. Facility leadership have submitted the required reports to the ISDH regarding resident Vand U's missing medications and also filed police reports with the Zionsville City Police. 2. All residents have the potential to be affected by this alleged deficient practice. The facility leadership reviewed all current resident medication records (MARs) to determine if there were any additional concerns of missing narcotic medications. No additional concerns were identified and no new items were identified as needing to be reported to ISDH. 3. The regional director of operations has reviewed the ISDH Unusual Occurrences policy and facility procedures pertaining to this ISDH policy with the administrator, wellness directors and key department supervisors. The Executive Director will also review with all staff the ISDH unusual occurrences reporting guidelines and their responsibility to report any possible concerns immediately to a supervisor or administrator. .</p> <p>4. The administrator and/or designee will conduct a review of</p>	06/04/2015

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	<p>he believed someone took 50 Norco (a narcotic pain medication) tablets he stored in his room. The ED indicated the Director of AL notified her via telephone of the allegation and indicated facility staff was unaware the resident had the medication in his room. The ED indicated she did not report the allegation of the missing narcotic pain medication to the State agency. She indicated the facility only reported when the investigation was complete and the facility was able to prove "wrong doing."</p> <p>2. Resident T's record was reviewed on 4/30/15 at 2:00 p.m. Resident T had diagnoses which included cancer, pressure ulcers, and pain.</p> <p>A physician's order, dated 2/3/15, indicated Hydrocodone/Acetaminophen (narcotic pain medication) 5/325 milligrams (mg) every evening at bedtime for pain.</p> <p>A physician's order, dated 2/3/15, indicated Hydrocodone/Acetaminophen 5/325 mg every four hours for pain.</p> <p>A pharmacy invoice, indicated thirty Hydrocodone/Acetaminophen 5/325 mg tablets were delivered for Resident T on 2/16/15.</p>		<p>all grievance and incident reports toensure proper reporting, when applicable. An audit review will be conducted weekly x 4 weeks, monthly x 2 monthsand quarterly thereafter. Results of theseaudits will be reviewed by the QA Committee, who will establish the thresholdof compliance and make further recommendations accordingly. These systematic changes will be completed byJune 4, 2015.</p>				

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	<p>A Medication Administration Record (MAR), dated 2/2015, indicated Resident T was administered Hydrocodone/Acetaminophen 5/325 mg 1 tab at bedtime on 2/16 & 2/17/2015. The MAR indicated, "no supply available" from 2/18/15-2/28/15, for Hydrocodone/Acetaminophen 5/325 mg at bedtime for pain.</p> <p>The record indicated Resident T was admitted to a hospital on 3/8/15 and had not returned.</p> <p>A drug reconciliation record dated 3/5/15, indicated on 3/20/15, Licensed Practical Nurse (LPN) #1 documented he administered Hydrocodone/Acetaminophen 5/325 mg one tab to Resident T at 4:00 p.m. and again at 9:00 p.m.</p> <p>During an interview on 5/4/15 at 10:00 a.m., with the ED and Memory Care Director present, the Assisted Living Care Director indicated the facility was unable to account for 28 Hydrocodone/Acetaminophen 5-325 mg tablets that were delivered for Resident T. The ED indicated Resident T did not return to the facility after her hospitalization on 3/8/15 and was not present in the facility when LPN #1 signed out the narcotic for administration</p>			

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R 241 Bldg. 00	<p>to the resident. The ED indicated the incident was not reported to the State agency. She indicated the facility only reported when the investigation was complete and the facility was able to prove "wrong doing."</p> <p>This residential rule relates to complaint IN00171525.</p> <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 record review and interview, the facility failed to ensure medication was administered as ordered by the physician for 2 of 7 residents reviewed for medication administration (Resident T and Resident U).</p> <p>Findings include:</p> <p>1. Resident T's record was reviewed on</p>	R 241	R 241 Health Services – medication administration 1. The concerns identified by the surveyor regarding unavailable medications for Residents T and U cannot be corrected because T has since vacated and U is in rehab. Chart reviews indicated no documented adverse outcomes during the time periods when their medications were not available. 2. All residents have	06/04/2015

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	<p>4/30/15 at 2:00 p.m. Resident T had diagnoses which included cancer, pressure ulcers, and pain. The record indicated the facility stored and administered her medication.</p> <p>Physician's orders, dated 2/3/15, indicated Hydrocodone/Acetaminophen (narcotic pain medication) 5/325 milligrams (mg) every four hours and at bedtime for pain.</p> <p>The Medication Administration Record (MAR), dated February 2015, indicated, "no supply available" from 2/3/15 through 2/15/15 and from 2/18/15 through 2/28/15, for Hydrocodone/Acetaminophen 5/325 mg every four hours and every evening at bedtime for pain.</p> <p>During an interview on 5/4/15 at 9:50 a.m., Licensed Practical Nurse (LPN) #7, indicated the pharmacy, physician, family, and Care Director should have been notified when the medication was unavailable for administration.</p> <p>During an interview on 5/4/15 at 10:00 a.m., with the Executive Director (ED) and Memory Care Director present, the Assisted Living (AL) Director indicated staff should have utilized the back up pharmacy to obtain the unavailable</p>		<p>the potential to beaffected by this alleged deficient practice. The facility wellness directorsand designees audited all current resident medication administration records(MARs) and medication carts to ensure that resident medications were accountedfor and in stock. Availability of emergency medication kit and local back uppharmacy service were confirmed. Any concerns were immediately addressed vianotification to physician, resident, resident representative and pharmacy andresolution of the concern. . 3. Theregional nurse consultant in-serviced nursing leadership on the facility's "Missed and Refused Medication" policy and procedure. Wellness Directors then in-services alllicensed nurses and Q.M.A.'s on the same policy and procedure. Items reviewed included medication orderingprocess, notification guidelines when meds are refused or not available, anduse of EDK and back up pharmacy, when needed. 4. Thewellness director nd/or designee will conduct an audit review of ten residentMARs for completion and availability of all medications. Review will be conducted 3 times a week x 1month, weekly x 2 months, monthly x 2 months and quarterly thereafter. Results of these audits will be reviewed bythe QA Committee, who will</p>	

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	<p>medications. The AL Director indicated she was not informed Resident T did not receive the medications as ordered by the physician.</p> <p>2. Resident U's record was reviewed on 4/30/15 at 12:50 p.m. Resident U had a diagnoses of insomnia. The record indicated the facility administered her medication.</p> <p>A physician's order, dated 3/10/15, indicated Ambien (sleep aide) 10 milligrams (mg) every evening for insomnia.</p> <p>The Medication Administration Record (MAR), dated 3/15, indicated Ambien 10 mg was "not available" from 3/10/15-3/17/15.</p> <p>During an interview on 5/4/15 at 9:50 a.m., Licensed Practical Nurse (LPN) #7, indicated the pharmacy, physician, family, and Care Director should have been notified when the medication was unavailable for administration.</p> <p>During an interview on 5/4/15 at 10:00 a.m., with the ED and Memory Care Director present, the AL Director staff should have utilized the back up pharmacy when residents' medications were not available to ensure the</p>		<p>establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by June 4, 2015.</p>				

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R 297 Bldg. 00	<p>medications were administered as ordered by the physician. The AL Director indicated she was not informed the resident did not receive the medications as ordered.</p> <p>A policy titled "Missed/Refused Medications Reporting" identified as current by the Executive Director on 5/4/15 at 9:10 a.m., indicated, "...Physician's Orders and/or recommendations will be followed appropriately...."</p> <p>This residential rule relates to complaint IN00171525.</p> <p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and and record review, the facility failed to ensure prescribed medications were available for 2 of 7 residents reviewed for nursing services related to pharmaceuticals (Resident T and Resident U).</p>	R 297	R 297 Pharmaceutical Services – medications 1. The concerns identified by the surveyor regarding unavailable medications for Residents T and U cannot be corrected because T has since vacated and U is in rehab. Chart reviews indicated no	06/04/2015

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	<p>Findings include:</p> <p>1. Resident T's record was reviewed on 4/30/15 at 2:00 p.m. Resident T had diagnoses which included cancer, pressure ulcers, and pain. The record indicated the facility stored and administered her medication.</p> <p>Physician's orders, dated 2/3/15, indicated Hydrocodone/Acetaminophen (narcotic pain medication) 5/325 milligrams (mg) every four hours and at bedtime for pain.</p> <p>The Medication Administration Record (MAR), dated February 2015, indicated, "no supply available" from 2/3/15 through 2/15/15 and from 2/18/15 through 2/28/15, for Hydrocodone/Acetaminophen 5/325 mg every four hours and every evening at bedtime for pain.</p> <p>During an interview on 5/4/15 at 9:50 a.m., Licensed Practical Nurse (LPN) #7, indicated the pharmacy, physician, family, and Care Director should have been notified when the medication was unavailable for administration.</p> <p>During an interview on 5/4/15 at 10:00 a.m., with the Executive Director (ED)</p>		<p>documented adverse outcomes during the timeperiods when their medications were not available.</p> <p>2. All residents have the potential to beaffected by this alleged deficient practice. The facility wellness directors and designees audited all currentresident medication administration records (MARs) and medication carts toensure that resident medications were accounted for and in stock. Availabilityof emergency medication kit and local back up pharmacy service were confirmed. Anyconcerns were immediately addressed via notification to physician, resident, resident representative and pharmacy and resolution of the concern. 3. Theregional nurse consultant in-served nursing leadership on the facility's "Missed and Refused Medication" policy and procedure. Wellness Directors then in-services alllicensed nurses and Q.M.A.'s on the same policy and procedure. Items reviewed included medication orderingprocess, notification guidelines when meds are refused or not available, anduse of EDK and back up pharmacy, when needed. . 4. Thewellness director nd/or designee will conduct an audit review of ten residentMARs for completion and availability of all medications. Review will be conducted 3 times a week x 1month, weekly x 2 months, monthly x 2 months and</p>	

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	<p>and Memory Care Director present, the Assisted Living (AL) Director indicated staff should have utilized the back up pharmacy to obtain the unavailable medications. The AL Director indicated she was not informed Resident T did not receive the medications as ordered by the physician.</p> <p>2. Resident U's record was reviewed on 4/30/15 at 12:50 p.m. Resident U had a diagnoses of insomnia. The record indicated the facility administered her medication.</p> <p>A physician's order, dated 3/10/15, indicated Ambien (sleep aide) 10 milligrams (mg) every evening for insomnia.</p> <p>The Medication Administration Record (MAR), dated 3/15, indicated Ambien 10 mg was "not available" from 3/10/15-3/17/15.</p> <p>During an interview on 5/4/15 at 9:50 a.m., Licensed Practical Nurse (LPN) #7, indicated the pharmacy, physician, family, and Care Director should have been notified when the medication was unavailable for administration.</p> <p>During an interview on 5/4/15 at 10:00 a.m., with the ED and Memory Care</p>		<p>quarterly thereafter. Results of these audits will be reviewed by the QA Committee, who will establish the threshold of compliance and make further recommendations accordingly. These systematic changes will be completed by June 4, 2015.</p>				

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	<p>Director present, the AL Director staff should have utilized the back up pharmacy when residents' medications were not available to ensure the medications were administered as ordered by the physician. The AL Director indicated she was not informed the resident did not receive the medications as ordered.</p> <p>A policy titled "Missed/Refused Medications Reporting" identified as current by the Executive Director on 5/4/15 at 9:10 a.m., indicated, "...Physician's Orders and/or recommendations will be followed appropriately...."</p> <p>This residential rule relates to complaint IN00171525.</p>						