STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERS OF NEW CASTLE THE	1000 N 16TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for the Investigation of Complaint IN00138213. Complaint IN00138213 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F514. Survey dates: October 23 and 24, 2013 Facility number: 000201 Provider number: 155304 AIM number: 100267910 Survey team: Penny Marlatt, RN Census bed type: SNF: 4 SNF/NF: 43 Total: 47 Census payor type: Medicare: 17 Medicaid: 22 Other: 8 Total: 47 Sample: 3 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action inparticular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulartory requirements. Our date of compliance is 11/23/2013.	

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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	Quality review complete on October 31, 2013, by Janelyn Kulik, RN.			

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F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on interview and record review, the facility failed to notify the attending physician for 2 of 3 residents reviewed for medication administration in a sample of 3 of	F000157	It is the intent of this facility to ensure physician notifications are made related to medications not available or refused after two consecutive doses as well as concerns related to a physician	11/23/2013

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	medications not available or refused after two consecutive doses, as well as concerns related to a physician-ordered medication in which the resident had a documented allergy to the medication. (Resident #A and Resident #C) Findings include: 1. Resident #A's clinical record was reviewed on 10-23-13 at 2:50 p.m. Her diagnoses included, but were not limited to cystic fibrosis and pneumonia. Review of Resident #A's October, 2013 Medication Administration Record (MAR), it indicated the following medications were indicated to not have been administered as ordered by the physician with encircled initials or by a blank entry with no initials on the indicated date, and without any notation as to why the medication was not administered: -folic acid 1 mg by mouth on 10-6-13 and 10-7-13 at 9:00 a.m. -linezolid 600 mg by mouth on 10-7-13 at 9:00 a.m. -pancrelipase 24,000 units delayed release capsules,4 capsules, with meals, by mouth on 10-6-13 at 7:00 a.m., 12:00 p.m. and 5:00 p.m. and on 10-7-13 at 12:00 p.m. and 5:00		ordered medication in which the resident had a documented allergy to the medicaiton. 1. Corrective action for affected residents Resident A is no longer in the facility. Resident C's physician was notified of the medication not given. 2. Other residents with the potential to be affected -audit completed for all residents current MAR, documentation and notifications made as needed on 11/12/2013 by DON/designee. 3. Measures to prevent reoccurrence:-Inservice completed for licensed nurses re: Drug Administration--General Guidelines. Coaching/counseling for individual nurses. DON/designee to review the MAR and clinical record 4 times a week for 2 months then 2 times a week for 2 months, then weekly for 2 months to ensure documentation and physician notification is completed for medications not administered. 4. Monitoring of corrective action to ensure the practice will not recur:- The DON/designess will complete a monthly summary audit to be presented to the monthly QA Committee with the Administrator related to documentation and physician notification for medications not administered. Monthly Summary will again be presented to the Quarterly QA committee with the Administrator and Medical Director. 5. The date	

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	p.m. -pancrelipase 24,000 units delayed release capsules, 3 capsules, with snacks, by mouth at 9:00 a.m., 2:00 p.m. and 9:00 p.m. on 10-6-13 and 10-7-13. -Lyrica 25 mg by mouth at 9:00 a.m. and 9:00 p.m. on 10-6-13 and 10-7-13. -Hyper-Sal 7% inhalation 4 ml via nebulizer at 6:00 p.m. on 10-6-13; at 6:00 a.m. and 6:00 p.m. on 10-7-13. -ciprofloxacin 400 mg via IV every 8 hours, once only, on 10-6-13 or 10-7-13. Review of the nursing progress notes and the reverse portion of the MAR, there were no entries which indicated the physician had been notified of the resident not receiving the medications for two or more consecutive doses. In an interview with RN #3 on 10-24-13 at 3:15 p.m., she indicated the ciproflaxin IV order had not been given as the facility's pharmacy complany had notified the facility of a listed allergy of the resident to this specific medication. She indicated she passed this information on to the next shift on 10-6-13 of the need to notify the physician for clarificaiton of the order. She indicated she had contacted the physician on 10-6-13		systematic changes will be completed and who will be responsible: -The DON/designee will be responsible for on-going compliance.-Date of Compliance: 11/23/13	

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	regarding the resident's compliant of her heart racing, being short of breath and request to be sent to the emergency room, which was approved. She indicated she did not discuss any other issues with the physician. She indicated the physician she spoke with was the physician on call for the attending physician. She indicated she was unsure if the physician had been notified as she was not working for several days after this and when she returned to work, the resident was no longer in the facility. In review of the nursing progress notes and the reverse portion of the MAR, there were no entities which indicated the physician had been notified of the resident's allergy to the ordered medicaiton. 2. Resident #C's clinical record was reviewed on 10-24-13 at p.m. Her diagnoses included, but were not limited to, Stage 3 kidney failure, uncontrolled diabetes, congestive heart failure, atrial fibrillation, anticoagulant therapy, history of deep vein thrombosis, morbid obesity and anxiety. Review of Resident #C's September, 2013 MAR, it indicated the following medications were indicated to not			

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	have been administered as ordered by the physician with encircled initials or by a blank entry with no initials on the indicated date, and without any notation as to why the medication was not administered: -Multaq 400 mg by mouth at 9:00 a.m. on 9-24-13 and 9:00 p.m. on 9-23-13 and 9-24-13. In an interview with LPN #1 on 10-23-13 at 6:15 p.m., RN #2 on 10-24-13 at 2:23 p.m. and RN #3 on 10-24-13 at 3:15 p.m., each indicated it is typical practice to circle the initials of the medication administrator on the MAR when a medication is not received or is refused by the resident, with a notation placed on the back side of the MAR to explain why the medication was not administered to the resident. In these same interviews, RN #2 and RN #3 indicated if a medication is unavailable for several doses or a resident would refuse a medication for several doses, each would notify the physician of the situation. On 10-24-13 at 11:45 a.m., the Director of Nursing provided a copy of a policy entitled, "Drug Administration--General Guidelines." This policy was indicated to be the current policy in use and had a date			

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	of revision indicated as 6-19-12. This policy indicated, "...Medications are administered in accordance with written orders of the attending physician...The resident's MAR is initialed by the person administering a medication, in the space provided under the dated,, and on the line for that specific medication dose administration...If a regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. If two consecutive doses of a medication are withheld or refused, the physician is notified..." This Federal tag relates to Complaint IN00138213. 3.1-5(a)(3)			

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F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure correct documentation of medication administration was conducted for 2 of 3 residents reviewed for medication administration in a sample of 3. (Resident #A and Resident #C) Findings include: 1. Resident #A's clinical record was reviewed on 10-23-13 at 2:50 p.m. Her diagnoses included, but were not limited to cystic fibrosis and pneumonia. Review of the admission nursing assessment, dated 10-6-13, indicated the resident was alert and oriented to person, place, time and event. Review of the Medication	F000514	It is the intent of this facility to ensure correct documentation of medication administration. 1. Corrective action for affected residents- Resident A is no longer in the facility.-Resident C's MAR for October 1 thru November 7 reviewed, no errors found in documentation. 2. Other residents with potential to be affected:- Audit completed for all residents current MAR documentation :-3. Measures to prevent reoccurrence: Inservice completed for licensed nurses re: Drug Administration--General Guidelines. Coaching/counseling for individual nurses. DON/designee to review the MAR and clinical record 4 times a week for 2 months then 2 times a week for 2 months, then weekly for 2 months to ensure documentation is completed for medications not	11/23/2013

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	Administration Record (MAR) for October, 2013, indicated on 10-7-13, the resident was documented to have received the following physician-ordered medications at 9:00 a.m.: -azithromycin 500 milligrams (mg) by mouth. -Symbicort aerosol inhalation 80 mg/4.5 micrograms (mcg) 2 puffs by mouth. -cholecalciferol 1000 units by mouth. -diltiazem 120 mg ER (extended release) by mouth. -dornase alfa 25 mg/2 milliter's (ml) via nebulizer inhalation. -Flonase 50 mcg 2 sprays in both nostrils. -pancrelipase 24,000 units delayed release capsules, 3 capsules, by mouth. In an interview with LPN #1 on 10-23-13 at 5:45 p.m., she indicated she had worked with Resident #A on 10-7-13 from 7:00 a.m. until 7:00 p.m. She indicated the resident was nauseated that day and ended up in the emergency room after lunch that day. She indicated she had attempted 3 different times to offer the resident her morning medications, both oral and respiratory treatments, but the resident declined to do so due to the nausea. She indicated, "It		administered. 4. Monitoring of corrective action to ensure the practice will not recur:- The DON/designess will complete a monthly summary audit to be presented to the monthly QA Committee with the Administrator related to documentation of medications not administered. Monthly Summary will again be presented to the Quarterly QA committee with the Administrator and Medical Director. 5. The date systematic changes will be completed and who will be responsible: -The DON/designee will be responsible for on-going compliance.-Date of Compliance: 11/23/13	

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	looks like [on the MAR] I forgot to circle [my initials]." In interview with LPN #1 on 10-23-13 at 6:15 p.m., she indicated, "Normally, if someone refuses or doesn't take a med, we circle it [the initials of the administrator] on the MAR and write a short note on the back of the MAR as to why. Like I said before, she didn't take any of her po [oral] meds or her breathing meds or treatments." In an interview with Resident #A on 10-24-13 at 9:33 a.m., she indicated on the morning of 10-7-13, she was nauseated and was concerned she might vomit and chose not to take her medications for that reason. In continued review of Resident #A's October, 2013 MAR, it indicated the following medications were indicated to not have been administered as ordered by the physician with encircled initials or by a blank entry with no initials on the indicated date, and without any notation as to why the medication was not administered: -cholecalciferol 1000 units by mouth on 10-6-13 at 9:00 a.m. -folic acid 1 mg by mouth on 10-6-13 and 10-7-13 at 9:00 a.m. -linezolid 600 mg by mouth on 10-7-13 at 9:00 a.m. -melatonin 3 mg by moth on 10-7-13			

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	at 9:00 p.m. -omeprazole 20 mg by mouth on 10-7-13 at 6:00 p.m. -pancrelipase 24,000 units delayed release capsules,4 capsules, with meals, by mouth on 10-6-13 at 7:00 a.m., 12:00 p.m. and 5:00 p.m. and on 10-7-13 at 12:00 p.m. and 5:00 p.m. -pancrelipase 24,000 units delayed release capsules, 3 capsules, with snacks, by mouth at 9:00 a.m., 2:00 p.m. and 9:00 p.m. on 10-6-13 and 10-7-13. -Lyrica 25 mg by mouth at 9:00 a.m. and 9:00 p.m. on 10-6-13 and 10-7-13. -Hyper-Sal 7% inhalation 4 ml via nebulizer at 6:00 p.m. on 10-6-13; at 6:00 a.m. and 6:00 p.m. on 10-7-13. -ciprofloxacin 400 mg via IV every 8 hours, once only, on 10-6-13 or 10-7-13. In an interview with RN #2 on 10-24-13 at 2:23 p.m. and RN #3 on 10-24-13 at 3:15 p.m., both indicated it is typical practice to circle the initials of the medication administrator on the MAR when a medication is not received or is refused by the resident, with a notation placed on the back side of the MAR to explain why the medication was not administered to the resident.			

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	2. Resident #C's clinical record was reviewed on 10-24-13 at p.m. Her diagnoses included, but were not limited to, stage 3 kidney failure, uncontrolled diabetes, congestive heart failure, atrial fibrillation, anticoagulant therapy, history of deep vein thrombosis, morbid obesity and anxiety. Review of Resident #C's September, 2013 MAR, it indicated the following medications were indicated to not have been administered as ordered by the physician with encircled initials or by a blank entry with no initials on the indicated date, and without any notation as to why the medication was not administered: -Toprol XL 50 mg by mouth at 9:00 p.m. on 9-23-13. -Multaq 400 mg by mouth at 9:00 a.m. on 9-24-13 and 9:00 p.m. on 9-23-13 and 9-24-13. -potassium chloride 10 meq ER, 4 tablets, by mouth at 9:00 a.m. on 9-27-13. On 10-24-13 at 11:45 a.m., the Director of Nursing provided a copy of a policy entitled, "Drug Administration--General Guidelines." This policy was indicated to be the current policy in use and had an date			

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	of revision indicated as 6-19-12. This policy indicated, "...Medications are administered in accordance with written orders of the attending physician...The resident's MAR is initialed by the person administering a medication, in the space provided under the dated,, and on the line for that specific medication dose administration...If a regularly scheduled medication is withheld, refused, or given at other than the scheduled time (e.g., resident not in facility at scheduled dose time, initial dose of antibiotic), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. If two consecutive doses of a medication are withheld or refused, the physician is notified..." This Federal tag relates to Complaint IN00138213. 3.1-50(a)(1) 3.1-50(a)(2)			