STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155777	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREASY SPRINGS HEALTH CAMPUS	1750 S CREASY LN LAFAYETTE, IN 47905

(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 Recertification and State Licensure survey. This visit included a Residential Licensure Survey. Survey dates: July 29,30,31, August 1,4, and 5, 2014. Facility Number: 012285 Provider Number: 155777 AIM Number: 201006770 Survey Team: Maria Pantaleo, RN, TC Rita Mullen, RN Bobette Messman, RN Holly Duckworth, RN Census bed type: SNF: 45 SNF/NF: 16 Residential: 52 Total: 113 Census payor type: Medicare: 17 Medicaid: 10 Other: 86 Total: 113 Residential Sample: 10 These deficiencies reflect state findings	F000000	The submission of this Plan of Correction does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Creasy Springs Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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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	cited in accordance with 410 IAC 16.2. Quality Review was completed by Tammy Alley RN on August 11, 2014.			
F000278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a			

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	material and false statement. Based on record review and interview, the facility failed to correctly code residents on Hospice as having a prognosis of six months or less on the Minimum Data Set (MDS) assessments for 2 of 3 residents residents reviewed for Hospice and life expectancy in a sample of 3. (Resident #55, and #145) Findings include. 1. The clinical record of Resident #55 was reviewed on 8/1/14 at 12:18 p.m. Diagnoses included, but were not limited to, anxiety, depression, dementia, incontinence, aggression and left femur fracture. A Physician's order dated 3/7/14, indicated "[name of hospice] to eval [evaluate] & tx [treat]." A Physician's order, dated 3/12/14, indicated " Admit to [name of hospice] [with]Admission diagnosis of Alzheimer's Dementia End Stage." A Letter, signed by (name of doctor) on 5/29/14, indicated the resident had a life expectancy of six months or less. A Quarterly Minimum Data Set (MDS) assessment, dated 6/19/14, indicated	F000278	CORRECTIVE ACTION: The MDS assessment was modified for resident #55 and #145 to accurately reflect that the resident was receiving hospice services and included a certification of terminal illness by the physician. IDENTIFY OTHER RESIDENTS: A review of all MDS assessments for health center residents receiving hospice services was completed. There were 6 other residents identified as to having hospice services and the certification of terminal illness was obtained by the physician. All of the MDS will be modified to reflect life expectancy of less than six months and the certification of terminal by the physcian will be available in the medical record. MEASURES/SYSTEMIC CHANGES: The MDS Coordinator or designee will review all medical records of residents with hopsice services to ensure that the certification of terminal illness by the physcician is present in the medical record and answered appropriately on the MDS assessment. An in-service will be conducted on August 27 and 29, for nurses to ensure understanding of the need for the prognosis order related to admission to hospice services. MONITORING CORRECTIVE ACTION: The MDS Coordinator or designee will audit physician orders for admission to	09/04/2014

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	Resident #55 was on Hospice and did not have a prognosis of less than six months. 2. The clinical record of Resident #145 was reviewed on 8/1/14 at 9:37 a.m. Diagnosis included, but were not limited to, dementia with behaviors, anxiety, reflux and weak gait. The resident was admitted to the facility on 5/15/14. A Physician's History and Physical Examination, dated 5/20/14, indicated the resident had a "poor potential due to end-stage dementia." A physician's order, dated 5/9/14, indicated "I certify that the patient's prognosis is six months or less if the disease runs it's normal course. Terminal diagnosis is dementia." An Admission MDS assessment, dated 5/15/14, indicated the resident was on Hospice and did not have a prognosis of less than six months. During an interview with the MDS coordinator, on 8/4/14 at 10:15 a.m., she indicated without a physician's verification, the resident only has six months or less to live, the MDS could not be coded for a prognosis of less than six months.		hospice to ensure the certification of terminal illness is completed by the physician, available in the medical record, and MDS answered appropriately. The audit will be conducted for all residents with hospice services for six months and will be reported at the monthly QA meeting.	

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	3.1-31(g)			
F000282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to administer medication within the parameters of physician orders and failed to reassess residents following PRN (as needed) medications. This deficient practice affected 4 of 5 residents reviewed for unnecessary medications (Residents #25, #45, #62, and #63). Findings include: 1. A record review for Resident #62 was completed on 8/4/14 at 8:44 a.m.	F000282	CORRECTIVE ACTION: The nurses and QMA were re-educated regarding lack of documentation by the nurse on blood pressures prior to administration of medication and on the effectiveness post narcotic. The QMA assigned to the resident was re-educated on prn medication administration which included the requirement that the nurse must authorize, assess need, and document the assessment prior to administration of the prn medication. IDENTIFY OTHER RESIDENTS: Audits will be conducted and review of the	09/04/2014

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	Diagnoses included, but were not limited to, embolic cerebrovascular accident, atrial fibrillation, hypertension, bradycardia, and dementia with behavioral symptoms. Physician orders, dated 01/04/2013, indicated "...Lisinopril [blood pressure medication] 10 mg [milligram] tablet...give 1 tablet by mouth every bedtime for HTN [hypertension]...hold for SBP [systolic blood pressure] less than 110...." A review of medication administration records (MAR), dated 6/01/2014 through 7/31/2014, indicated the following: Resident #62 was administered lisinopril without first obtaining a blood pressure on 06/01/2014 and 07/03/2014. MAR documentation for 6/30/2014 indicated that Resident #62 was administered lisinopril with a blood pressure of 107/68, which was outside of the parameters of the physician order. 2. A record review for Resident #63 was completed on 08/04/2014 at 1:25 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, depression, and hypertension		MARs of all residents that are receiving anti-pressure medications to ensure that blood pressure and pulse are documented prior to administration of hypertensive medications, and following the parameters as MD order. Audits will also include QMA administration of prn medications for proper assessement and co-signing of the nurse. MEASURES/SYSTEMIC CHANGES: Nurses and QMAs will be re educated on following MD orders in regards to anti-hypertensive medication and parameters on August 27 and 29. The inservice will also include the guidelines for prn narcotic medication and documenting effectiveness as well as co-signing after a QMA. MONITOR CORRECTIVE ACTIONS: The Director of Health Services or designee will review the MARS to ensure that nurses are following the parameters for administration of medication for accuracy as well as monitor for follow up on PRN medication and documentation. Audits will be conducted two times per week x 4 weeks then monthly for 6 months to ensure that the nurses are following MD parameters in regards to anti-pressure medication. The audit will be reported to the QA Committee monthly.	

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	Physician orders, dated 06/19/2013, indicated "...Amlodipine [blood pressure medication] 5 mg tablet...give 1 tablet by mouth daily...hold for SBP [systolic blood pressure] < [less than] 110...." A review of MARs, dated 6/01/2014 through 7/31/2014, indicated the following: Resident #63 was administered amlodipine without first taking a blood pressure on 06/07/2014, 07/06/2014, 07/13/2014, and 07/17/2014. 3. A record review for Resident #25 was completed on 08/04/2014 at 9:59 a.m. Diagnoses included, but were not limited to, hypertension, pulmonary embolism/deep vein thrombosis, and dementia with agitated behaviors. Physician orders, dated 04/29/2011, indicated "...Metoprolol succ [succinate] ER [extended release] 25 mg [blood pressure medication]...give 1 tablet by mouth twice daily for HTN [hypertension]...hold if BP [blood pressure] <100 or pulse <50...." A review of MARs, dated 6/01/2014 through 07/31/2014, indicated the following:			

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	Resident #25 was administered metoprolol without first taking a pulse on 06/01/2014 (no pulse prior to a.m. or p.m. dose). Resident #25 was administered metoprolol without first taking a pulse or blood pressure on 06/19/2014, 06/30/2014, 07/01/2014, 07/02/2014, 07/09/2014, and 07/17/2014. Documentation for 07/31/2014 indicated metoprolol was administered with a blood pressure of 88/40, which was outside of physician ordered parameters. During an interview with the Director of Health Services (DHS) on 08/05/2014 at 10:05 a.m., she indicated physician orders should be followed. She also indicated initials on the MAR indicate a medication was administered, unless the initials were circled. Additional information was requested from the DHS related to the missing vital signs. During an interview on 08/05/2014 at 4:15 p.m., the DHS indicated she had no further information to provide. 4. A July 2014 PRN medication tracking form was reviewed for Resident #25 on 08/05/14 at 10:30 a.m. The form indicated the following:			

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	Resident #25 received 1 tablet of Norco 5/325 (pain medication) on 07/12/2014 at 6:20 p.m. A follow up for medication effectiveness was not completed. Resident #25 received Tylenol 650 mg on 07/28/2014 at 4:20 p.m. A follow up for medication effectiveness was not completed. 5. The clinical record of Resident #45 was reviewed on 8/4/14 at 10:00 a.m. Diagnoses included, but were not limited to, high blood pressure, congestive heart failure, depression and pain. Resident was admitted to the facility on 2/2/14. A Medication Administration Record, dated for the month of July 2014, indicated the resident had a physician's order for Norco (a narcotic pain medication) 5/325 mg every 4 hours as needed (PRN) and Ativan (an anti-anxiety medication) 0.5 mg every 6 hours as needed. A PRN Medication Tracking record, dated for the month of July 2014, indicated Qualified Medication Assistant #1 administered PRN Norco 5/325 mg three times and Ativan 0.5 mg three times during the month. There was no follow-up by the nurse as to the effectiveness of the			

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	PRN medication. During an interview with the Director of Heath Services, on 8/5/14 at 11:40 a.m., she indicated the nurse is to co-sign with the QMA and do a follow-up assessment of residents receiving PRN medication. 6. An "Administration of PRN Medications Guideline," (no date), received from the Director of Health Services, on 8/5/14 at 1:00 p.m., indicated the following: "...4. If PRN medication is to be administered by a QMA the Standards of Practice for PRN medication administration by a Qualified Medication Assistant shall be observed. 5. Follow up should be noted to ensure the effectiveness and/or assess for adverse side effects." 3.1-35(g)(2)			
F000309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of			

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	care. Based on record review and interview, the facility failed to verify the Hospice diagnosis and prognosis with the resident's physician for 1 of 2 resident's reviewed for Hospice services in a sample of 3. (Resident #85) Findings include: The clinical record of Resident #85 was reviewed on 8/5/14 at 9:00 a.m. Diagnoses included but were not limited to, high blood pressure, advanced dementia with behaviors and chronic kidney disease. Resident was admitted to the facility on 9/19/12, readmit on 5/15/13 and returned 7/5/14. A Physician's order, dated 7/8/14, indicated "Admitted to [name of Hospice] 7/5/14 Dx [diagnosis] Dementia, end stage." A Quarterly Minimum Data Set (MDS) assessment, dated 6/18/14, indicated the resident was on hospice but did not have a prognosis of less than six months. During an interview with the MDS coordinator, on 8/4/14 at 10:15 a.m., she indicated without a physician's	F000309	CORRECTIVE ACTION: A corrected MDS assessment was completed for resident #85 to reflect that the resident was receiving hospice services and a certification of terminal illness was obtained by the physician. IDENTIFY OTHER RESIDENTS: A review of MDS of all residents receiving hospice services was conducted. There were 6 other residents which were identified as having hospice services and the certification of terminal illness was obtained by the physician. All of the MDS will be modified to reflect life expectancy of less than six months and the certification of terminal illness by the physician will be available in the medical record. MEASURES/SYSTEMIC CHANGES: The MDS Coordinator or designee will review all medical records of residents with hospice services to ensure that the certification of terminal illness by the physician is present in the medical record, and the MDS is accurate. The need for the certification of terminal illness will be discussed at the inservices August 27 and August 29. MONITOR CORRECTIVE ACTIONS: The MDS Coordinator or designee will review all physician orders for admission to hospice to ensure the certification of terminal illness	09/04/2014

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	verification the resident only has six months or less to live, the MDS could not be coded for a prognosis of less than six months. Hospice was not contacted for a terminal diagnosis. 3.1-37(a)		is written by the attending physician, is present in the medical record, and the MDS is marked appropriately. The results of the audit will be reported to the QA Committee each month.	
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless			

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	antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to adequately monitor blood pressure medication for 3 of 5 residents reviewed for unnecessary medications (Residents #25, #62, and #63). Findings include: 1. A record review for Resident #62 was completed on 8/4/14 at 8:44 a.m. Diagnoses included, but were not limited to, embolic cerebrovascular accident, atrial fibrillation, hypertension, bradycardia, and dementia with behavioral symptoms. Physician orders, dated 01/04/2013, indicated "...Lisinopril [blood pressure medication] 10 mg [milligram] tablet...give 1 tablet by mouth every bedtime for HTN [hypertension]...hold for SBP [systolic blood pressure] less than 110...." A review of medication administration records (MAR), dated 6/01/2014 through	F000329	CORRECTIVE ACTION: The nurse who administered blood pressure medication without documenting blood pressure was inserviced. IDENTIFY OTHER RESIDENTS: All residents receiving anti hypertensives have the potential to be affected by the deficient practice. Audits are being conducted and review of the MARs of all residents that are receiving anti-pressure medications to ensure that blood pressure and pulse are documented prior to administration of hypertensive medications and following the parameters of MD order. MEASURES/SYSTEMIC CHANGES: CHANGES: Licensed nursing staff will be educated on following physician orders in regards to anti-hypertensive medication and parameters on August 27 and 29. MONITORING CORRECTIVE ACTIONS: The Director of Health Services or designee will conduct audits and review the MARs to ensure that nurses are following the parameters for administration of medication for accuracy two times a week x 4 weeks then monthly for six	09/04/2014

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	7/31/2014, indicated the following: Resident #62 was administered lisinopril without first obtaining a blood pressure on 06/01/2014 and 07/03/2014. MAR documentation for 6/30/2014 indicated that Resident #62 was administered lisinopril with a blood pressure of 107/68, which was outside of the parameters of the physician order. 2. A record review for Resident #63 was completed on 08/04/2014 at 1:25 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, depression, and hypertension Physician orders, dated 06/19/2013, indicated "...Amlodipine [blood pressure medication] 5 mg tablet...give 1 tablet by mouth daily...hold for SBP [systolic blood pressure] < [less than] 110...." A review of MARs, dated 6/01/2014 through 7/31/2014, indicated the following: Resident #63 was administered amlodipine without first taking a blood pressure on 06/07/2014, 07/06/2014, 07/13/2014, and 07/17/2014. 3. A record review for Resident #25 was		months and will be reported at the monthly QA meeting.	

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	completed on 08/04/2014 at 9:59 a.m. Diagnoses included, but were not limited to, hypertension, pulmonary embolism/deep vein thrombosis, and dementia with agitated behaviors. Physician orders, dated 04/29/2011, indicated "...Metoprolol succ [succinate] ER [extended release] 25 mg [blood pressure medication]...give 1 tablet by mouth twice daily for HTN [hypertension]...hold if BP [blood pressure] <100 or pulse <50...." A review of MARs, dated 6/01/2014 through 07/31/2014, indicated the following: Resident #25 was administered metoprolol without first taking a pulse on 06/01/2014 (no pulse prior to a.m. or p.m. dose). Resident #25 was administered metoprolol without first taking a pulse or blood pressure on 06/19/2014, 06/30/2014, 07/01/2014, 07/02/2014, 07/09/2014, and 07/17/2014. Documentation for 07/31/2014 indicated metoprolol was administered with a blood pressure of 88/40, which was outside of physician ordered parameters.			

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	During an interview with the Director of Health Services (DHS) on 08/05/2014 at 10:05 a.m., she indicated physician orders should be followed. She also indicated initials on the MAR indicate a medication was administered, unless the initials are circled. Additional information was requested from the DHS related to the missing vital signs. During an interview on 08/05/2014 at 4:15 p.m., the DHS indicated she had no further information to provide. 3.1-48(a)(3)			
R000000	The following residential findings were cited in accordance with 410 IAC 16.2-5	R000000	The submission of this Plan of Correction does not indicate an admission by Creasy Springs Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Creasy Springs Health Campus. This facility recognized it's obligation to provide legally and medically	

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			necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities. To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R000121	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12)			

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	months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure a new employee was given a second step TB (tuberculin) skin test. This effected 1 of 5 new employees screened and reviewed for pre-employment TB testing. (Environmental Assistant #2) Findings include: Employee records reviewed on 8/1/14 at 1:30 p.m. The following item was not found: The second step TB skin test for Environmental Assistant #2, hired on	R000121	**CORRECTIVE ACTION:** On 8/1/2013 1 employee was given the first step PPD. The second step PPD was given on 8/19/2014. **IDENTIFY OTHER EMPLOYEES**: All current employees medical files are currently being audited to ensure that the first step and second step PPDs were administered and read. **MEASURES/SYSTEMIC CHANGES**: The Staff Development Nurse will track all employee PPDs that are due with a 12-month calendar. **MONITORING CORRECTIVE ACTIONS:** The business office will audit all new hires medical file for the previous month each month to ensure that new employees have both first and	09/04/2014

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	6/17/14. During an interview with the Director of Health Services on 8/4/14 at 1:23 p.m., she indicated the second step TB skin test was not completed for the Environmental Assistant #2.		second step PPDs completed. Results of the monthly audit will be forwarded to the QA committee monthly for six months.	
R000246	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure a PRN (as needed) medication was authorized by a nurse prior to administration by a qualified medical assistant (QMA), for 1 of 7 residents reviewed for authorized PRN medications. (Resident # 164) Findings include: The record for Resident #164 was reviewed on 8/5/2014 at 10:50 a.m. Diagnoses for Resident # 164 included, but were not limited to, congestive heart	R000246	**CORRECTIVE ACTION:** The QMA assigned to Resident # 164 was re-educated in regards to obtaining the proper authorization prior to administering an "as needed" medication from a Nurse. **IDENTIFY OTHER RESIDENTS:** All residents have the potential to be deficient of the same deficient practice. Audits are being conducted on all residents under the care of QMAs that received PRNs to ensure that the Nurse is authorizing and documenting on the prn tracking form per policy. **MEASURES/SYSTEMIC**	09/04/2014

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	failure, muscle weakness, hypertension, anemia, dementia, hypothyroidism, urinary obstruction, hepatitis, sepsis, pneumonia, and macular degeneration of the retina. The July 2014 Medication Administration Record (MAR), indicated a physician's order, dated 1/28/14, for acetaminophen 325 mg (milligrams), give 2 tablets (650 mg) orally every 4 hours as needed for pain or fever. The July 2014 MAR indicated on 7/31/2014, at 1:30 p.m., acetaminophen was given to Resident # 164 by QMA #1 without prior nurse authorization. During an interview with RN # 3, on 8/5/2014 at 11:00 a.m., she indicated QMA # 1 failed to obtain the proper authorization prior to administering an "as needed" medication. On 8/5/2014 at 1:00 p.m., the Director of Healthcare Services, provided the Administration of PRN Medication Guideline Policy, undated and currently used by the facility. The policy indicated " ...4. If PRN medication is to be administered by a QMA the Standards of Practice for PRN medication administration by a Qualified Medication Assistant shall be		**CHANGES:** The Nurses and QMAs will be inserviced on August 27 and 29 regarding PRN Medication Guidelines Policy and the standard practice. **MONITORING CORRECTIVE ACTIONS:** The Director of Health Services or designee will audit the prn tracking form to ensure that the Nurse is authorizing and documenting for those residents receiving PRNs by a QMA two times a week x 4 weeks then monthly for six months and will be reported at the monthly QA meeting.	

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	observed....".			
R000349	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview the facility failed to ensure that an assessment was completed for the effectiveness of PRN (as needed) medication for 2 of 7 resident reviewed for PRN medications. (Resident # 164 and # 167) Findings include: 1. The record for Resident #164 was reviewed on 8/5/2014 at 10:50 a.m. Diagnoses for Resident #164 included, but were not limited to, congestive heart failure, muscle weakness, hypertension, anemia, dementia, hypothyroidism, urinary obstruction, hepatitis, sepsis, pneumonia, and macular degeneration of the retina.	R000349	**CORRECTIVE ACTION:** The QMA assigned to Resident # 164 received re-education in regards to obtaining the proper authorization prior to administering an "as needed" medication from a Nurse. **IDENTIFY OTHER RESIDENTS:** An audit was done on all residents that received PRNs by a QMA to ensure that the nurse is authorizing and documenting on the MARs in accordance with the QMA standards of practice. No other resident was affected by this practice. **MEASURES/SYSTEMIC CHANGES:** The Staff Nurses and QMA will be re-inserviced on August 27 and 29 regarding prn medication Guidelines Policy and the standard practice. **MONITORING CORRETIVE ACTIONS:** The Director of	09/04/2014

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	A physician's order, dated 1/28/2014, indicated acetaminophen 325 mg (milligrams) tablets, take 2 tablets (650 mg) by mouth every 4 hours as needed for pain or fever. The July 2014 Medication Administration Record (MAR), indicated the acetaminophen medication was administered on 7/26, and 7/31, but there was no documentation for medication effectiveness. A physician's order, dated 7/27/14, indicated Tylenol 160 mg/5 ml (milliliters) elix.(elixir), take 10.2 ml by mouth every 4 hours as needed for pain. The July 2014 MAR, indicated the Tylenol medication was administered on 7/28, but there was no documentation for medication effectiveness. During an interview with RN #3, on 8/5/2014 at 11:00 a.m., she indicated the staff should have documented the effectiveness for the as needed order for acetaminophen and Tylenol exlir given on 7/26, 7/28, and 7/31/2014. 2. The record for Resident #167 was reviewed on 8/5/2014 at 1:30 p.m. Diagnoses for Resident # 167 included,		Health Services or designee will audit the MARS to ensure that the Nurse are authorizing and documenting for those residents receiving PRNs and are given by a QMA. The audit will be conducted two times a week x 4 weeks then monthly for six months and will be reported at the monthly QA meetings.	

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	but were not limited to, congestive heart failure, muscle weakness, hypertension, anemia, dementia, hyperthyroidism, pneumonia, hyperlipidemia, renal failure, dementia, and acute respiratory failure. A physician's order, dated 12/8/2010, indicated arth (arthritis) pain relief 650 mg tab(tablet), give 2 tabs by mouth every 8 hours as needed for pain or headache. The April 2014 MAR, indicated the arthritis pain relief medication was administered on 4/4/14, but there was no documentation for medication effectiveness. During an interview with LPN #4, on 8/5/2014 at 2:20 p.m.,she indicated the staff should have documented the effectiveness for the PRN for arthritis pain relief medication given on 4/4/ 2014. 3. On 8/5/2014 at 1:00 p.m., the Director of Healthcare Services, provided the Administration of PRN Medication Guideline, undated and currently used by the facility. The policy indicated: " ...5. Follow up should be noted to ensure the effectiveness and /or assess for adverse side effects."			

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