

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155751	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/03/2016
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NAME OF PROVIDER OR SUPPLIER MEADOW LAKES	STREET ADDRESS, CITY, STATE, ZIP CODE 200 MEADOW LAKE DR MOORESVILLE, IN 46158
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey Dates: January 25, 26, 27, 28, 29, February 1, 2, and 3, 2016.</p> <p>Facility number: 004831 Provider number: 155751 AIM number: 200809750</p> <p>Census bed type: SNF: 18 SNF/NF: 106 Residential: 52 Total: 176</p> <p>Census payor type: Medicare: 32 Medicaid: 69 Other: 23 Total: 124</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on February 12, 2016.</p>	F 0000	<p>Meadow Lakes is requesting a Face to Face Informal Dispute Resolution in regards to F166, F282 & F323 and respectfully requests additional evidentiary information be considered to delete and/or reduce the previous mentioned deficiencies The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the provider to its residents</p>	
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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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F 0246 SS=D Bldg. 00	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on interview and record review, the facility failed to ensure a resident was bathed according to their preferences as indicated by facility policy for 1 of 2 residents who met the criteria for review of choices. (Resident #80).</p> <p>Findings include:</p> <p>On 1/27/2016 at 1:27 p.m., Resident #80 indicated, "I prefer a tub bath, but I only get bed baths and a shower. I have told the staff numerous times that I prefer a tub bath but all they ever say is, we'll see."</p> <p>Resident #80's clinical record was reviewed on 2/1/2016 at 11:00 a.m. Diagnosis included, but were not limited to chronic obstruction pulmonary disease (COPD) and diabetes mellitus.</p> <p>The Minimum Data Set (MDS)</p>	F 0246	<p>F 246 REASONABLE ACCOMMODATION OFNEEDS/PREFERENCES</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·The facility reviewed resident #80's preferences for a customary routine and activities with the resident. The residents care plan and profile were updated with her current preferences. The resident was bathed per her preference. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice. ·An audit will be completed on or before 03/03/16 on all residents to verify their current bathing 	03/03/2016

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	<p>assessment completed on 1/30/2016, indicated Resident #80 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was interviewable and cognitively intact.</p> <p>On 2/1/2016 at 2:15 p.m., Unit Manager #1 (UM) for the 600 hall provided the Resident Profile dated 1/19/2016, for Resident #80's bath preference. The profile indicated, "I prefer a tub bath two times per week, and a partial bath in between."</p> <p>On 2/1/2016 at 3:02 p.m., the Executive Director (ED) provided Resident Progress Note dated 1/25/2016 at 2:05 p.m. The progress note indicated, Resident #80 "... prefers a tub bath twice a week in either the morning or evening ..."</p> <p>On 2/1/2016 at 2:36 p.m., UM #1 provided the Activity Of Daily Living (ADL) log for Resident #80. The log indicated Resident #80 had received a bed bath 28 times and a shower 1 time since her readmission date of 1/18/2016. The ADL log lacked evidence that a tub bath had been given.</p> <p>On 2/1/2016 at 2:16 p.m., UM #1 indicated Resident #80's preference is a tub bath, but staff will ask her each bath</p>		<p>preference.</p> <ul style="list-style-type: none"> ·Facility staff will be in-serviced by theCEC or designee by 03/03/16 on resident preferences, resident profiles, andensuring residents a bathed per their preference. ·The IDT team will be in-serviced onresident preferences and CP/resident profile updating on or before 03/03/16 bythe ED or designee. <p>What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·Facility staff will be in-serviced bythe CEC or designee by 03/03/16 on resident preferences, resident profiles, andensuring residents a bathed per their preference. ·The IDT team will be in-serviced onresident preferences and CP/resident profile updating on or before 03/03/16 bythe ED or designee. ·Activity Director or designee willcomplete the Preferences for Daily Customary Routines worksheet upon admissionof a new resident, quarterly and upon significant change of a resident. Theinterview will be conducted with the resident unless they are not able to beunderstood. If the resident is not able to be understood, the worksheet iscompleted with the family/significant other, as available. The information 		

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	<p>night if she wants a tub bath or a shower. The resident does not have any health condition preventing her from taking a tub bath. The Certified Nursing Assistants (CNA's) will look at resident preferences on the kiosk before giving a resident a bath or they can look at a copy in the binder. The facility does have a nice tub bath with jets.</p> <p>On 2/1/2016 at 2:31 p.m., Resident #80 indicated, she has only had one shower since she has been at the facility. She generally washes herself up in the bathroom. Staff has never asked her prior to bathing if she would prefer a tub bath, shower or a bed bath.</p> <p>On 2/2/2015 at 4:47 p.m., CNA #2 indicated, Resident #80 is asked each bath night if she prefers a shower, tub or bed bath. She prefers a bed bath. She has never asked for a tub bath and has refused a tub bath when offered.</p> <p>On 2/1/2016 at 2:30 p.m., UM #1 provided the Shower Report for Resident #80 dated 1/27/2016. The report indicated Resident #80 "refused shower x 3."</p> <p>A careplan initiated on 1/19/2016 with current goal date through 4/19/2016, for Resident #80 indicated a problem of:</p>		<p>from the worksheet will be shared with the interdisciplinary team so that each department can address the resident's preferences and update the resident's profile and CP as needed. Prior to bathing a resident the facility staff will review the resident's CP or profile to ensure the resident's preference is being followed.</p> <p>The DNS or designee will audit newly completed resident preference sheets daily to ensure the profile and CP are updated appropriately. The DNS or designee will review shower sheets daily to ensure residents are being bathed per their preference.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>To ensure compliance the DNS/Designee will complete a resident bathing preference CQI audit tool (Attachment #2) for six months with audits being completed once weekly for one month, and then monthly for 5 months by the DNS or designee. The resident preference CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed.</p>	

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F 0278 SS=D Bldg. 00	<p>"...Self care deficit related to: Weakness/Debility, admitted from home CHF (congestive heart failure)/COPD, resident is unable to complete adl (activity of daily living) care needs without staff assistance ... Approach: I prefer a tub bath two times per week, and partial bath in between ... [sic]."</p> <p>On 2/2/2016 at 11:40 a.m., the Assistant Executive Director provided the booklet Resident Handbook, Residents' Rights and Advance Directives with a revised date of 9/2014. The booklet indicated, "... The resident has the right to ... (e) Accommodation of needs ... (3) Make choices about aspects of his or her life in the facility that are significant to the resident ..."</p> <p>3.1-3(v)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>		Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.				

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	<p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>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.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the accuracy of the quarterly Minimum Data Set (MDS) assessment in that a resident on an anticoagulant medication (blood thinner) was assessed as not taking the medication for 1 of 5 residents reviewed for unnecessary medications. (Resident #133)</p> <p>Findings include:</p> <p>Resident #133's clinical record was reviewed on 2/1/2016 at 1:30 p.m. Diagnoses included, but were not limited to atrial fibrillation.</p>	F 0278	<p>F278Assessment Accuracy/Coordination/Certified</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #133's MDS was modified to indicate the resident is taking an anticoagulant <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents on anticoagulants have the potential to be affected by the alleged deficient practice. ·An audit will be completed on or before 03/03/16 by the DNS or 	03/03/2016

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	<p>Current February 2016 Physician's orders indicated, 12/14/2015 (start date) Coumadin (anticoagulant medication) 2.5 milligrams (mg) once a day.</p> <p>The quarterly MDS dated 1/14/2016 assessed Resident #133 as taking an anticoagulant medication 0 out of 7 days.</p> <p>On 2/1/2016 at 2:13 p.m., License Practical Nurse #3 (LPN) indicated Resident #133 had been on Coumadin 2.5 mg once a day since 12/15/2015, and no doses had been held due to abnormal lab values since that date.</p> <p>On 2/1/2016 at 2:56 p.m., the MDS Coordinator indicated the quarterly MDS for Resident #133 was coded incorrectly and should have been coded as taking an anticoagulant the last 7 out of 7 days. She indicated she would get that modified as soon as possible.</p> <p>On 2/02/2016 at 11:25 a.m., the Executive Director indicated the facility does not have a policy related to the accuracy of the MDS.</p> <p>3.1-31(i)</p>		<p>designee on residents who are on an anticoagulant to ensure their MDS is coded correctly.</p> <p>·MDS staff will be in-serviced by the Director of Nursing Services or designee by 03/03/16 on accurate assessment and MDS coding of residents who are on an anticoagulant.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·MDS staff will be in-serviced by the Director of Nursing Services or designee by 03/03/16 on accurate assessment and MDS coding of residents who are on an anticoagulant.</p> <p>·When MDS completes the medication section N of the MDS, the MDS personnel will review the medical record for orders and administration history of anticoagulants. The MDS personnel will then code section N of the MDS for anticoagulants correctly.</p> <p>·On the day of transmission MDS assessments will be audited by the DNS or Designee for accuracy of those residents who are on an anticoagulant.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·To ensure compliance the</p>		

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F 0281 SS=D Bldg. 00	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure a resident rinsed their mouth and spit after administration of a steroid inhaler for 1 of 1 residents observed for inhaled medication administration in a sample of 7 residents reviewed for medication administration. (Resident #239)</p> <p>Findings include Resident #236's clinical record was</p>	F 0281	<p>MDS coordinator/Designee will complete the MDS Coding of anticoagulant CQI audit tool (Attachment #3) for six months with audits being completed once weekly for one month, and then monthly for 5 months by the MDS coordinator or designee. The MDS coding of anticoagulant CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee</p> <p>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident #239 has had her mouth rinsed after administration of her steroid inhaler ·LPN #1 was educated on medication pass and ensuring that residents rinse their mouths after administration of</p>	03/03/2016

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	<p>reviewed on 2/3/16 at 1:50 p.m. Diagnosis included but, were not limited to: asthma.</p> <p>Physician's order dated 1/3/16 through 2/3/16, indicated Qvar inhaler take 2 puffs twice a day.</p> <p>On 02/01/2016 8:35 a.m., Licensed Practical Nurse (LPN) #1 was observed to administer Qvar inhaler (treatment of asthma) to Resident #239. Resident #239 was observed taking 2 puffs as ordered without rinsing and spitting after the administration. LPN #1 was not observed to have Resident # 239 to rinse and spit after using the inhaler. LPN #1 indicated she should have had Resident #239 rinse after using the inhaler. "I should have told her to rinse."</p> <p>On 2/3/16 at 1:27 p.m.. the Executive Director (ED) provided the policy "Metered Dose Inhaler Medication Administration Guidelines" dated 2/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "...14.0 The Nurse should allow resident to rinse their mouth with water. ..."</p> <p>Review of QVAR.com " ...Important Safety Information ...QVAR may cause serious side effects, including: Fungal</p>		<p>steroidinhalers.</p> <p>How will you identify other residents havingthe potential to be affected by the same deficient practice and what correctiveaction will be taken?</p> <ul style="list-style-type: none"> ·All residents on steroid inhalers have the potential to be affected by the alleged deficient practice. ·All nurses will be in-serviced by theCEC or designee by 03/03/16 on medication pass and to ensure that residents whoreceive steroid inhalers rinse their mouths afterwards. ·All nurses will complete a skillsvalidation on medication pass on or before 03/03/16. <p>What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All nurses will be in-serviced by theCEC or designee by 03/03/16 on medication pass and to ensure that residents whoreceive steroid inhalers rinse their mouths afterwards. ·All nurses will complete a skillsvalidation on medication pass on or before 03/03/16. ·When a nurse administers a steroidinhaler the nurse will ensure that the resident rinses his or her mouth afterthe administration. ·The DNS or designee will round daily toobserve medication pass <p>How the corrective action(s) will be monitoredto ensure the</p>				

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F 0425 SS=D Bldg. 00	<p>infections (thrush). Rinse your mouth after using QVAR to help prevent an infection in your mouth or throat."</p> <p>3.1-35(g)(1)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each</p>		<p>deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·To ensure compliance the DNS/Designee will complete a medication pass skills validation audit (Attachment #4) for six months with audits being completed twice weekly for one month, and then monthly for 5 months by the DNS or designee. The medication pass skills validations will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee</p>	

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	<p>resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to ensure a resident's medication was available for administration for 1 of 7 residents review for medication administration. (Resident #62)</p> <p>Findings include:</p> <p>Resident #62's clinical record was reviewed on 2/2/16 at 2:00 p.m. Diagnosis include but, were not limited to: dementia, hypertension and anemia.</p> <p>On 2/1/16 at 5:32 a.m., LPN #2 was observed during medication administration not to administer Resident #62's potassium due to the medication not being available. LPN #2 indicated she needed to get the potassium from the EDK (Emergency Drug Kit), because there was no potassium available in Resident #62's medications. There was no documentation provided indicating potassium was removed from the EDK.</p> <p>On 02/02/16 2:12 p.m., review of Resident #62's Medication Administration Record (MAR) indicated</p>	F 0425	<p>F425PHARMACEUTICAL SVC-ACCURATE</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> Resident #62's medications were audited and any missing medication was ordered from pharmacy. All medications are currently available for the resident. LPN #2 was educated on appropriate ordering of medications and the use of the facility EDK and med select machine. <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> All residents who receive medications have the potential to be affected by the alleged deficient practice. Facility nurses will be in-serviced on the appropriate process for ordering medications, getting needed medications from the EDK/medselect, and that borrowing medications from other residents is prohibited by the CEC or designee on or before 03/03/2016 	03/03/2016

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	<p>potassium was administered at 5:00 a.m. on 2/1/16.</p> <p>On 2/2/16 at 2:30 p.m., an interview with the Unit Manager/Assistant Director of Nursing indicated LPN #2 had borrowed 20 meq potassium (miliequivalent) from Resident #18 to give to Resident #62 on 2/1/16 with the intention to replace once Resident #62's potassium came in.</p> <p>On 2/3/16 at 1:30 p.m., the Executive Director provided policy "Re-orders:Refills on Demand" dated 4/2014, and indicated the policy was the one currently used by the facility. The policy indicated, " ...1. It is recommended that refills be requested by the nursing staff two to four [2-4] days prior to the resident's current supply being exhausted.</p> <p>3.1-25(a) 3.1-25 (b)(7) 3.1-25 (g)(3)</p>		<p>·Themedications carts were audited on or before 03/03/16 to ensure there are nomissing medications that need ordered. Any missing medications will be ordered appropriately.</p> <p>What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur?</p> <p>·Facilitynurses will be in-serviced on the appropriate process for ordering medications,getting needed medications from the EDK, and that borrowing medications from other residents is prohibited by theCEC or designee on or before 03/03/2016</p> <p>·Whena nurse passes medications and a medication is noted to not be available he orshe will notify the pharmacy that the medication needs filled. The nurses will then go to the EDK/med selectand remove the medication and administer to the resident if the medication isavailable. If the medication is notavailable the medication should be ordered from the pharmacy and the MD andfamily will be notified of a late administration. If medications are not onauto refill they should be ordered 2 to 4 days prior to the supply beingexhausted.</p> <p>·The DNS or designee will round eachshift to check and ensure the nurses have ordered</p>	

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F 0431 SS=E Bldg. 00	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and		and administered resident medications appropriately. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? To ensure compliance the DNS/Designee will complete the Medication ordering/administration CQI audit tool (Attachment #8) for six months with audits being completed once weekly for one month, and then monthly for 5 months by DNS or designee. The Medication CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and including termination of the responsible employee	

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	<p>periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on interview and record review, the facility failed to accurately reconcile and account for all controlled medications according to current facility policy for 2 of 5 medication carts. (200 hall)(600 hall)</p> <p>Findings include:</p> <p>On 02/02/16 8:54 a.m., during a narcotic count on the 200 hall with the 200 hall Unit Manager indicated the following:</p>	F 0431	<p>F431DRUG RECORDS LABEL/STORE DRUGS & BIOLOGICALS</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·All medication carts were reviewed. The narcotics were counted and all were accounted for. The shift to shift countsheets were updated after the count. ·Resident #236, #237, and #2's narcotic sheets were reviewed to ensure the medications were 	03/03/2016

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	<p>1). Resident #2's narcotic sheet for hydrocodone 5/325 mg (pain medication) indicated there were 5 tablets when there were 4 tablets remaining. LPN #1 indicated she had not signed the narcotic out, but the medication had been given.</p> <p>2). Resident #236's narcotic sheet for modafinil 100 mg (treat sleep disorders) daily indicated there were 13 tablets when there were 12 tablets remaining. LPN #1 indicated she had not signed the narcotic out, but the medication had been given.</p> <p>3). Resident #237's narcotic sheet for lorazepam 0.5 mg (treats anxiety) indicated there were 34 tablets when there were 33 tablets remaining. LPN #1 indicated she had not signed the narcotic out but the medication had been given.</p> <p>4). The Substance Control sheet dated 12/31/15, had no reconciliation signature for the day shift and night shift.</p> <p>5). There was no Substance Control sheet for February 2016. LPN #1 indicated she had not signed the Substance Control sheet today nor for the month of February.</p> <p>On 02/02/2016 9:35 a.m., the 200 Hall Unit Manager provided a signed updated</p>		<p>signed out appropriately and the individual count is correct.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents who receive narcotic medications have the potential to be affected by the alleged deficient practice. ·All nurses will be in-serviced on the shift to shift narcotic count and the process for signing out narcotic medications on the narcotic log sheet after each administration by the CEC or designee on or before 03/03/2016. ·All medications carts were audited on or before 03/03/2016 and it was ensured that the narcotic count was accurate and documented on the shift to shift narcotic count sheet ·All individual narcotic count sheets were audited on or before 03/03/16 to ensure the individual medication count is accurate. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <ul style="list-style-type: none"> ·All nurses will be in-serviced on the shift to shift narcotic count and the process for signing out narcotic medications on the narcotic log sheet after each administration by the CEC or designee on or before 	

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	<p>February 2016, Substance Control sheet.</p> <p>On 02/02/2016 8:54 a.m., during a narcotic count on the 600 hall with RN #1 indicated the following:</p> <p>6).The Substance Control sheet dated 1/1/16, had one signature missing for the day shift.</p> <p>7). On 1/5/16 the signature was missing for evening shift.</p> <p>8). On 1/9/16 the signature was missing for day shift.</p> <p>9). On 1/10/16 the signature was missing for day shift and night shift.</p> <p>10).On 1/11/16 the signature was missing for night shift.</p> <p>11). On 1/28/16 the signature was missing for day shift.</p> <p>12). On 1/29/16 the signature was missing for the day shift.</p> <p>On 2/2/16 at 9:00 a.m., an interview with the 600 hall Unit Manager/Assistant Director of Nursing indicated the blank spaces on the Substance Control sheet was not signed by nurses.</p>		<p>03/03/2016.</p> <p>·When administering narcotics the nursewill sign off the medication on the narcotic sheet immediately before or afterthe administration. At the end of each shift the off going and oncoming nursewill count all narcotics and sign the shift to shift narcotic count sheetindicating the count is accurate. TheDNS will be notified of any discrepancies.</p> <p>·The DNS or designee will audit theindividual narcotic count sheets and the shift to shift count sheets daily toensure accuracy and appropriate documentation.</p> <p>How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place?</p> <p>·To ensure compliance the DNS/Designee will complete the Narcotic Count CQIaudit tool (Attachment #9) for six months with audits being completed onceweekly for one month, and then monthly for 5 months by the DNS or designee. TheNarcotic Count CQI audit tool will be reviewed monthly by the CQI Committee forsix months after which the CQI team will re-evaluate the continued need for theaudit. If a 95% threshold is not achieved an action plan will be developed.Deficiency in this practice will result in disciplinary action up to and orincluding</p>		

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R 0000 Bldg. 00	<p>On 2/2/16 at 11:19 a.m., the Executive Director (ED) provided policy "Med Pass General Guidelines" dated 2/2014, and indicated the policy was the one currently used by the facility. The policy indicated, "10.0 It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration....11.0 Controlled substances should be logged out in the narcotic log with each use...."</p> <p>3.1-25(n)</p>		<p>termination of the responsible employee.</p>	
	<p>This visit was for a State Residential Licensure Survey.</p> <p>Residential census: 52</p> <p>Sample: 7</p> <p>Meadow Lakes was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p>	R 0000	<p>Meadow Lakes is requesting a Face to Face Informal Dispute Resolution in regards to F166, F282 & F323 and respectfully requests additional evidentiary information be considered to delete and/or reduce the previous mentioned deficiencies The current statement of deficiencies on the 2567 omits significant facility information and therefore misrepresents the care and services administered by the</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

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	Q.R. completed by 14466 on February 12, 2016.		provider to its residents		