

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER TERRACE AT TOWNE CENTRE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7252 ARTHUR BLVD MERRILLVILLE, IN 46410
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R000000	<p>This visit was for the State Residential Licensure Survey.</p> <p>Dates of Survey: May 5 & 7, 2014</p> <p>Provider number: 002392 Facility number: 002392 AIM number: N/A</p> <p>Survey team: Cynthia Stramel, RN-TC Heather Tuttle, RN</p> <p>Census bed type: Residential: 47 Total: 47</p> <p>Census payer type: Other: 47 Total: 47</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 12, 2014, by Janelyn Kulik, RN.</p>	R000000		
R000216	<p>410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs</p>			

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>assessment shall include an evaluation of the following:</p> <p>(1) The resident ' s physical, cognitive, and mental status.</p> <p>(2) The resident ' s independence in the activities of daily living.</p> <p>(3) The resident ' s weight taken on admission and semiannually thereafter.</p> <p>(4) If applicable, the resident ' s ability to self-administer medications.</p> <p>(d) The evaluation shall be documented in writing and kept in the facility.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents were appropriately assessed to self administer medications to themselves related to the administration of multiple inhalers at the same time for 1 of 5 residents observed during medication pass. (Resident #10)</p> <p>Findings include:</p> <p>On 5/7/14 at 10:37 a.m., QMA #1 was observed preparing medication for Resident #10. At that time, she pulled out of the medication drawer two inhalers for the resident. The first inhaler was Advair 100/50, inhale one puff two times a day, and the second inhaler was Spirivia, inhale one capsule daily. The QMA indicated the resident usually gives himself the inhalers. She finished pouring the resident's oral medication and walked into his room with both inhalers and his medications and one cup of</p>	R000216	<p>1.Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;</p> <p>1.Resident # 10 The QMA was immediately removed fromher medication pass duties when errorswere reported and suspended pending further action and has been terminated</p> <p>2.Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken ;</p> <p>1.All residents'physician orders were reviewed to identify if any other resident had orders forinhalers and that order is clarified to include procedure for administration.</p> <p>3.Whatmeasures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>1.Anin-service will be provided to licensed professional nurses and certifiedmedication</p>	06/20/2014

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	<p>water. The QMA gave the resident his oral medication first. She then handed him the Advair inhaler. The resident placed the inhaler into his mouth and pressed the button on the inhaler and inhaled. He then repeatedly took two more breaths in and pressed the inhaler two more times within three seconds. The resident then tossed the inhaler onto his chair and grabbed the Spirivia inhaler and proceeded to do the same thing. He took a total of three inhalations and pressed the button on the inhaler three times. The resident completed this within 10 seconds. The resident then drank the rest of the water in the cup. He swallowed the water and did not rinse his mouth out afterwards. At that time, the QMA stood by the resident and watched him self administer his inhalers. At no time, did the QMA stop the resident and instruct him on the correct way to administer the inhalers. At no time, did the QMA instruct the resident to wait at least five minutes between inhalations and rinse his mouth out with the water and spit it out versus swallowing the water.</p> <p>Interview with QMA #1 at that time, indicated she was unaware the resident had to spit out the water afterwards, she had thought he could just swallow the water. The QMA was also unaware of</p>		<p>assistants on the procedure for inhaler administration that will also include the policy for medication administration.</p> <p>4. 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>1. A medication pass observation skill check will be completed on licensed professional nurses and certified medication assistants and then will be done annually and as needed. The medication pass observations will be conducted by consultant nurses and or consultant pharmacist.</p> <p>2. Report of medication pass observations will be reviewed at Quarterly QAIS</p> <p>5. By what date the systemic changes will be completed</p> <p>1. The systemic changes will be completed by June 20, 2014</p>				

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R000241	<p>how long to wait between the administration of two different inhalers.</p> <p>The Record for Resident #10 was reviewed on 5/7/14 at 10:47 a.m. The resident's diagnoses included, but were not limited to COPD (Chronic Obstructive Pulmonary Disease), Congestive Heart Failure, and dyspnea.</p> <p>Review of Physician Orders on the current 5/2014 recap indicated Advair Diskus 100/50 inhale one puff two times a day. Rinse mouth with water after use. Spiriva inhale the contents of one capsule daily.</p> <p>Review of the current 5/5/14 service plan indicated, "All meds administered per Nurse or QMA." The resident was not assessed as being able to self administer his own medications.</p> <p>Interview with the Director of Nursing on 5/7/14 at 11:30 a.m., indicated the resident was not assessed as being able to self administer his own medications. She further indicated it was the facility's policy that no resident was able to self administer their own medications.</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</p>			

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	<p>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 observation, record review, and interview, the facility failed to ensure Physicians Orders were followed as written related to providing a treatment to an open wound for 1 of 7 sampled residents, and the administration of medications for 3 of 5 residents observed during medication pass. (Residents #4, #5, #9 and #10)</p> <p>Findings include:</p> <p>1. On 5/7/14 at 7:45 a.m., QMA #1 was observed preparing and pouring medications for Resident #9. At that time, she removed a bottle of Atorvastatin (Lipitor) 10 milligrams (mg) and poured one pill into the med cup. She then removed a bottle of Potassium Chloride 10 milliequivalence (meq) and poured one pill into the med cup. She then finished the pouring the rest of the resident's medications. The QMA walked over to the resident who was sitting outside of the dining room and administered all of her medications. After the pass, the QMA walked back to the medication cart and signed out all of the medications using her initials.</p>	R000241	<p>1.Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice;</p> <p>1.Resident # 1The QMA was immediately removed from her medication pass duties when errors were reported andsuspended and subsequently terminated</p> <p>2.Resident# 4 The QMA was immediately removed from her medication pass duties when errorswere reported and suspended pending further action as needed.</p> <p>3. Resident #10 The QMA was immediately removedfrom her medication pass duties when errors were reported and suspended pendingfurther action as needed.</p> <p>4.Resident# 5 Dressing were changed when nurse was informed that dressing had not beenchanged.</p> <p>2.Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken ;</p> <p>1.Allresidents have the potential to be affected by QMA that was passing medication;therefore she was removed and suspended pending</p>	06/20/2014

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	<p>The record for Resident #9 was reviewed on 5/7/14 at 8:50 a.m. Review of Physician Orders dated 12/27/13 indicated Atorvastatin 40 mg one tablet daily and Potassium Chloride 10 meq two tablets daily.</p> <p>Review of the current 5/2014 Medication Administration Record (MAR) indicated Atorvastatin 40 mg daily and Potassium Chloride 10 meq two tablets daily.</p> <p>Interview with QMA #1 on 5/7/14 at 9:00 a.m., indicated she was unaware the bottle of the Atorvastatin medication was only 10 mg tablets. She further indicated the label on the bottle of Potassium Chloride only indicated to give one tablet.</p> <p>Interview with LPN #2 on 5/7/14 at 9:00 a.m., indicated the QMA should have compared the label and bottle of medication with the MAR. She further indicated the QMA should also have placed a red sticker on the bottle's label indicating there was a change in the order.</p> <p>2. On 5/7/14 at 8:40 a.m., QMA #1 was observed pouring medication for Resident #4. At that time, she removed a bottle of Lisinopril 40 milligrams (mg)</p>		<p>further investigation.</p> <p>2.Allresidents that were identified as having wounds were assessed and dressing wereapplied and or changed per physician orders.</p> <p>3.Whatmeasures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>1.Anin-service will be presented on medication pass policy and procedure labelingof OTC medication and change in medication orders for nurses and CMA.</p> <p>2.MedicationPass skills observation will be conducted by nurse consultants or pharmacist toreview if medication is passed according to physician orders as well astreatment performed per physician orders</p> <p>3.Ameeting will be scheduled with Hospice Service to collaborate on how to improvecommunications.</p> <p>4.Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ;</p> <p>1.Medicationcart audits will be conducted weekly by Director of Nursing to ensuremedication bottles are labeled correctly and any discontinued medication havebeen sent to pharmacy and or destroyed per policy and any expired drugs havebeen removed and destroyed per facility policy.</p> <p>2.Resultsof audits will be</p>				

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	<p>and poured one whole tablet into the med cup. After finishing pouring all of the resident's medications, she walked into her room and administered the pills. After the pass, the QMA walked back to the medication cart and signed out all of the medications using her initials.</p> <p>The record for Resident #4 was reviewed on 5/5/14 at 10:37 a.m. Review of Physician Orders dated 4/23/14 indicated Lisinopril 20 mg daily.</p> <p>Interview with QMA #1 on 5/7/14 at 9:00 a.m., indicated she was aware the medication had been lowered, but again she indicated she did not compare the bottle of medication with the medication sheet.</p> <p>3. On 5/7/14 at 10:37 a.m., QMA #1 was observed preparing medication for Resident #10. At that time, she pulled out of the medication drawer two inhalers for the resident. The first inhaler was Advair 100/50, inhale one puff two times a day, and the second inhaler was Spirivia, inhale one capsule daily. The QMA indicated the resident usually gives himself the inhalers. She finished pouring the resident's oral medication and walked into his room with both inhalers and his medications and one cup of water. The QMA gave the resident his</p>		<p>presented at Quarterly QAIS meetings for review and will be ongoing for six months.</p> <p>3. A Communication Sheet will be developed to ensure hospice report to nurse that she is in facility and she will be providing service, hospice will also be required to inform nurse when care has been completed and they are exiting. A hospice file will be maintained by hospice nurse and kept at facility to ensure continuity of care. This will be ongoing</p> <p>5. By what date the systemic changes will be completed</p> <p>1. The systemic changes will be completed by June 20, 2014</p>				

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	<p>oral medication first. She then handed him the Advair inhaler. The resident placed the inhaler into his mouth and pressed the button on the inhaler and inhaled. He then repeatedly took two more breaths in and pressed the inhaler two more times within three seconds. The resident then tossed the inhaler onto his chair and grabbed the Spirivia inhaler and proceeded to do the same thing. He took a total of three inhalations and pressed the button on the inhaler three times. The resident completed this within 10 seconds. The resident then drank the rest of the water in the cup. He swallowed the water and did not rinse his mouth out afterwards. At that time, the QMA stood by the resident and watched him self administer his inhalers. At no time, did the QMA stop the resident and instruct him on the correct way to administer the inhalers. At no time, did the QMA instruct the resident to wait at least five minutes between inhalations and rinse his mouth out with the water and spit it out versus swallowing the water.</p> <p>Interview with QMA #1 at that time, indicated she was unaware the resident had to spit out the water afterwards, she had thought he could just swallow the water. The QMA was also unaware of how long to wait between the</p>			

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	<p>administration of two different inhalers.</p> <p>The Record for Resident #10 was reviewed on 5/7/14 at 10:47 a.m. Review of Physician Orders on the current 5/2014 recap indicated Advair Diskus 100/50 inhale one puff two times a day. Rinse mouth with water after use. Spiriva inhale the contents of one capsule daily.</p> <p>Review of the current 11/1/2006 Oral Inhalation Administration Policy provided by the Director of Nursing on 5/7/14 at 11:30 a.m., indicated "Shake the inhaler. Instruct the resident to tilt his/her head back slightly, stand or sit up as straight as possible, and breathe out through mouth. Place inhaler in mouth and instruct resident to inhale slowly as you depress the canister to release the medication. Breathe in an out normally for one minute, keeping the inhaler in the mouth. Have the resident rinse his or her mouth and spit out the rinse water."</p> <p>Review of the Spiriva instructions for use indicated, "Place the Spiriva Handihaler to your mouth and tightly seal your lips around the mouthpiece. Breathe in quickly and deeply through the Spiriva Handihaler. You should hear a rattling sound as you take a deep breath. This indicates the medication is being dispensed correctly from the capsule. If</p>			

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	<p>possible, hold your breath for five to ten seconds, then breathe out normally. Rinse your mouth with water or brush your teeth after each use."</p> <p>Review of the Advair instructions for use indicated, "Before you breathe in your dose from the DISKUS, breathe out (exhale) as long as you can while you hold the DISKUS level and away from your mouth. Do not breathe into the mouthpiece. Put the mouthpiece to your lips. Breathe in quickly and deeply through the DISKUS. Do not breathe in through your nose. Remove the DISKUS from your mouth and hold your breath for about 10 seconds, or for as long as is comfortable for you. Breathe out slowly as long as you can. The DISKUS delivers your dose of medicine as a very fine powder that you may or may not taste or feel. Do not take an extra dose from the DISKUS even if you do not taste or feel the medicine. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it."</p> <p>Interview with the Director of Nursing on 5/7/14 at 11:00 a.m., indicated the QMA should had administered the inhalers to the resident and she should have instructed the resident to rinse and spit the water out and not swallow it.</p>			

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R000246	<p>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the QMA was given authorization to administer PRN (as needed) medications from a licensed staff member for 1 of 5 residents observed during medication pass. (Resident #4)</p> <p>Findings include:</p> <p>On 5/7/14 at 8:40 a.m., QMA #1 was observed preparing medication for Resident #4. At that time, she pulled out a bottle of an over the counter medication of Equate Stool Softener. The QMA poured one pill into the plastic cup. The QMA then finished pouring the rest of the resident's medications and walked into her room and administered the medications to her including the stool softener,</p> <p>The record for Resident #4 was reviewed on 5/5/14 at 10:37 a.m. Review of</p>	R000246	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. Resident # 4 The QMA was immediately removed from her medication pass duties when errors were reported and suspended then terminated 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1. All residents have the potential to be affected by QMA that was passing medication; therefore she was removed and suspended pending further investigation. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; 1. A in-service on medication passes policy and the notification of nurse prior to administering any prn medication and or pain medication per facility policy. will</p>	06/20/2014			

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	<p>Physician orders dated 4/10/13 and on the current 5/2014 recap indicated Docusate Sodium (a stool softener) 100 milligrams twice a day PRN.</p> <p>Interview with QMA #1 on 5/7/14 at 9:00 a.m., indicated she did administer the stool softener without authorization from a licensed staff member. She further indicated the resident did not ask for the medication she just poured it and administered it to her.</p> <p>Interview with LPN #2 on 5/7/14 at 9:05 a.m., indicated the QMA knows she needed to ask licensed staff for authorization before administering PRN medication to residents.</p>		<p>be presented to nurse and QMA</p> <p>2. Medication Pass skills observation will be conducted by nurse consultants or pharmacist to review if medication is passed according to physician orders as well as medication pass policy and prn and or pain medication administration.</p> <p>4. 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>1. An MAR audit will be conducted by the DON weekly to ensure that prn medication administered by QMA has been signed off by nurse. This will be a weekly audit.</p> <p>2. Results of audits will be presented at Quarterly QAIS meetings for review and will be ongoing for six months.</p> <p>5. By what date the systemic changes will be completed</p> <p>1. The systemic changes will be completed by June 20, 2014</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>1. Resident # 4 The QMA was immediately removed from her medication pass duties when errors were reported and suspended pending further action as needed.</p> <p>2. How other residents having the potential to be affected by the</p>	

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NAME OF PROVIDER OR SUPPLIER TERRACE AT TOWNE CENTRE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 7252 ARTHUR BLVD MERRILLVILLE, IN 46410
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			<p>same deficientpractice will be identified and what corrective action(s) will be taken ;</p> <p>1.Allresidents have the potential to be affected by QMA that was passing medication;therefore she was removed and suspended pending further investigation.</p> <p>3.Whatmeasures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur;</p> <p>1.Anin-service on medication passes policy and the notification of nurse prior toadministering any prn medication and or pain medication per facilitypolicy. will be presented to nurse andQMA</p> <p>2.MedicationPass skills observation will be conducted by nurse consultants or pharmacist toreview if medication is passed according to physician orders as well asmedication pass policy and prn and or pain medication administration.</p> <p>4.Howthe corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ;</p> <p>1.AnMAR audit will be conducted by the DON weekly to ensure that prn medicationadministered by QMA has been signed off by nurse. This will be a weekly audit.</p> <p>2.Resultsof audits will be presented at Quarterly QAIS meetings for review and will beongoing for six month.</p>	

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R000300	<p>410 IAC 16.2-5-6(c)(4) Pharmaceutical Services - Deficiency (4) Over-the-counter medications, prescription 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.</p> <p>Based on observation, record review and interview, the facility failed to ensure expired medications were disposed of for 2 out of 2 medication storage rooms.</p> <p>Findings include:</p> <p>On 5/7/14 at 10:00 a.m., the medication storage room for the A and B halls was observed with LPN #1. The following bottles of resident medications in the storage room were expired:</p> <p>a. Tramadol, 50 milligrams (mg), expired 8/23/13.</p> <p>b. Meclizine, 12.5 mg, expired 8/30/13.</p> <p>c. Lisinopril, 40 mg, expired 12/2/13.</p> <p>d. Lisinopril, 40 mg, expired 10/5/13.</p>	R000300	<p>5. By what date the systemic changes will be completed 1. The systemic changes will be completed by June 20, 2014</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. No residents were identified 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1. All residents have the potential to be affected if expired medication is not destroyed. Expired medications were destroyed at time of notification per pharmacy and facility policy. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; 1. An in-service on expired medications and drug destruction will be presented by nurse consultant or pharmacy consultant to all nurses. 4. How the corrective action(s)</p>	06/20/2014			

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	<p>e. Potassium, 10 millequivalents, expired 3/25/12.</p> <p>f. Tramadol, 50 mg, expired 9/19/13.</p> <p>g. Lisinopril, expired 8/13/13.</p> <p>h. A vial of Humulin R insulin, opened on 9/25/13, discard after 28 days.</p> <p>The LPN indicated at that time that the medications were expired and should not be in the storage room.</p> <p>On 5/7/14 at 10:20 a.m., the medication storage room for the C and D halls was observed with LPN #1 and LPN #2. The following bottles of resident medications in the storage room were expired:</p> <p>a. Glyburide, 2.5 mg, expired 11/13/13.</p> <p>b. Glyburide, 5 mg, expired 11/13/13.</p> <p>c. Glyburide, 2.5mg, expired 1/31/14.</p> <p>d. Glyburide, 5 mg, expired 1/31/14.</p> <p>LPN #2 indicated the medications were expired and should have been disposed of.</p> <p>Interview with the Director of Nursing (DoN) on 5/7/14 at 1:10 p.m., indicated</p>		<p>will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ;</p> <p>1. A weekly audit of medication rooms and medication carts by Director of Nursing to ensure all expired medication has been destructed per facility policy.</p> <p>2. Results of audits will be presented at Quarterly QAIS meetings for review and will be ongoing for six month.</p> <p>5. By what date the systemic changes will be completed</p> <p>1. The systemic changes will be completed by June 20, 2014</p>				

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R000302	<p>expired medications should be disposed of per facility policy. She indicated staff should have monitored the medication storage rooms to ensure there were no expired medications.</p> <p>The policy Disposal of Medications, Syringes, and Needles received from the DoN at that time and identified as current, indicated expired medications were not acceptable for return to the Pharmacy. "These meds are to be written up and destroyed at the facility".</p> <p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength.</p> <p>Based on observation, record review, and interview, the facility failed to ensure over the counter medication were properly labeled with the resident's Physician's name for 2 of 5 residents observed during medication pass. (Residents #4 and #9)</p> <p>Findings include:</p> <p>1. On 5/7/14 at 7:45 a.m., QMA #1 was observed passing medications. At that</p>	R000302	<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1. Resident # 9 QMA was removed from medication pass upon notification of findings and suspended pending further investigation. Bottled was labeled per facility policy. 2. Resident #4 QMA was removed from medication pass upon notification of findings and suspended pending further investigation. Bottled was labeled</p>	06/20/2014

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	<p>time, she pulled a bottle of Bayer Aspirin 81 milligrams (mg) out of the medication drawer for Resident #9. Review of the over the counter medication indicated the resident's name was hand written on the bottle. There was no evidence of any documentation the name of the resident's Physician was written on the bottle.</p> <p>Interview with the Director of Nursing on 5/7/14 at 10:00 a.m., indicated all over the counter medication should be labeled with the resident's name and the name of their Physician. She indicated it was the responsibility of the QMAs to ensure those medication were labeled properly.</p> <p>2. On 5/7/14 at 8:40 a.m., QMA #1 was observed preparing medication for Resident #4. At that time, she pulled out a bottle of an over the counter medication of Equate Stool Softener, Vitamin B 12, and a bottle of a Multi Vitamin. All of these over the counter medications had only the resident's name on them. There was no evidence of any documentation the name of the resident's Physician was written on the bottles.</p> <p>Review of the current and undated, Medication Provided to a Resident by an Outside Agency policy, provided by the Director of Nursing on 5/7/14 at 1:10 p.m., indicated "All medications will be</p>		<p>per facility policy.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ;</p> <p>1. All residents that have over the counter medication had the potential to be affected as a result all medication carts were audited and OTC medication was labeled as required if necessary.</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>1. An in-service on correct labeling of OTC medication will be presented by nurse consultant and or pharmacist.</p> <p>4. 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>1. A weekly audit of medication carts to identify if OTC has been labeled will be completed by Director of Nursing and or designee.</p> <p>2. Results of audits will be presented at Quarterly QAIS meetings for review and will be ongoing for six months.</p> <p>5. By what date the systemic changes will be completed</p> <p>1. The systemic changes will be completed by June 20, 2014</p>	

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R000349	<p>labeled according to regulation, including the name of the resident, physician, drug, strength, directions, expiration date and dispensing pharmacy. Over the counter medications must be used from their original container. Attach a label to the bottle with the resident and physician name as not to obstruct the drug name, strength, and administration information...."</p> <p>Interview with the Director of Nursing on 5/7/14 at 10:00 a.m., indicated all over the counter medication should be labeled with the resident's name and the name of their Physician. She indicated it was the responsibility of the QMAs to ensure those medication were labeled properly.</p> <p>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 each resident's medical record was complete and accurate related to medications being</p>	R000349	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	06/20/2014

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	<p>signed out and follow up documentation and assessment after a change in condition for 2 of 7 residents reviewed for clinical records in the sample of 10. (Residents #2 and #4)</p> <p>Findings include:</p> <p>1. The record for Resident #2 was reviewed on 5/5/14 at 12:38 p.m. The residents diagnoses included but were not limited to, dyslipidemia.</p> <p>Review of the "Need for House Call" Progress Note completed by the Physician and faxed to the facility on 4/23/14 indicated, "Dyslipidemia-D/C (discontinue) statin."</p> <p>Review of Physician Orders dated 4/24/14 indicated D/C Vytorin (Simvastatin).</p> <p>Review of the current 5/2014 Medication Administration Record (MAR) indicated the Vytorin was signed out as being given on 5/1, 5/2, 5/3, and 5/4/14.</p> <p>Interview with QMA #2 on 5/5/15 at 2:45 p.m., indicated she had worked on 5/1, 5/3 and 5/4/14 and those were her initials that signed out the Vytorin. She further indicated she did not administer the medication because she knew it had been</p>		<p>1. Resident# 2 QMA was removed from medication pass upon notification of findings and suspended subsequently has been terminated</p> <p>2. Resident#4 an assessment was completed and documented determine of resident had any complaints of dizziness and BP was taken and was within limits of residents baseline.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ;</p> <p>1. All residents have the potential to be affected by QMA who documents medication as given when it has been discontinued. Also the statement that was made that she documented and did not provide medication. The QMA has been suspended until further investigation.</p> <p>3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>1. An in-service on medication pass policy and procedures will be presented to nurses and QMA</p> <p>2. An in-service on assessment and documentation will be presented to nurses.</p> <p>4. 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>				

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	<p>discontinued. The QMA had no explanation on why she had signed the medication as being administered.</p> <p>Interview with the Director of Nursing on 5/5/14 at 2:50 a.m., indicated the QMA should not have signed out the medication as being given if it was discontinued.</p> <p>2. The record for Resident #4 was reviewed on 5/5/14 at 10:37 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, angina, and dementia with psychosis.</p> <p>Review of Nursing Progress Notes dated 4/21/14 at 6:00 a.m., indicated "Resident had complaints of dizziness when laying down and standing up. Vital signs 110/52. MD (Medical Doctor) notified via text message. Awaiting reply. Next shift aware." The next documented entry in Nursing Progress Notes was on 4/22/14 at 9:00 a.m. (over 24 hours later) and there was no assessment or follow up documentation of the resident regarding her complaints of dizziness.</p> <p>Review of the current 5/2014 Physician recap indicated the resident was receiving Lisinopril (a medication used for high blood pressure) 40 milligrams (mg) daily, and Metoprolol (a medication used for</p>		<p>1. A daily audit of 24-hour report for condition change will be conducted by the DON and or designee.</p> <p>2. A daily audit of new physician orders will be conducted by DON to compare with MAR to ensure new medication orders or discontinued orders have been documented correctly on MAR.</p> <p>3. Results of audits will be presented at Quarterly QAIS meetings for review and will be ongoing for six months.</p> <p>5. By what date the systemic changes will be completed</p> <p>1. The systemic changes will be completed by June 20, 2014</p>	

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	<p>high blood pressure) 25 mg 1/2 tab twice a day.</p> <p>Review of the Treatment Administration Record and the Medication Administration Record for 5/2014 indicated there was no documentation or monitoring of the resident's blood pressure on 4/21, 4/22, or 4/23/14.</p> <p>Review of the "Need for House Call" Physician Progress Note dated 4/23/14 and faxed to facility on 4/23/14 indicated Lisinopril 20 mg daily.</p> <p>Interview with LPN #1 on 5/5/14 at 2:30 p.m., indicated there was no follow up assessment or documentation completed for the resident after she had complaints of dizziness.</p> <p>Interview with the Director of Nursing on 5/5/14 at 2:50 p.m., indicated she recalls having the nurses check the resident's blood pressure after the change in medication but not before. She indicated there was no evidence of any follow up assessment or documentation after the resident had complaints of dizziness.</p>			