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 07/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WILLOW LAKE	2725 LAKE CIRCLE DR INDIANAPOLIS, IN 46268

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: July 16 & 17, 2015 Facility number : 010234 Provider number: 010234 AIM number: N/A Census bed type: Residential : 55 Sample: 7 These State findings are cited in accordance with 410 IAC 16.2-5	R 0000	The following is the Plan of Correction for Brookdale Willow Lake in regards to the Statement of Deficiencies for the annual survey completed on July 17, 2015. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse			

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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	consequences or to commence a new form of treatment. Based on interview and record review, the facility failed to notify a Physician when a resident's medications were not administered as ordered for 1 of 5 residents reviewed for notification of physician for medication administration. (Resident #5) Findings include: The record for Resident #5 was reviewed on 7/17/15 at 11:09 a.m. Diagnoses included, but were not limited to, depression, gastroesophageal reflux disease, hypothyroidism, and asthma. a. A MAR dated June 2015, included, but was not limited to the following orders: 5/7/15--Levothyroxine (a thyroid medication) 100 mcg (micrograms) give one tablet by mouth every morning. The MAR dated June 2015, indicated from 6/15/15 to 6/24/15 at 6 a.m., all the nurses initials were circled on the 6 a.m., boxes for the Levothyroxine order for a total of 10 doses of levothyroxine were not administered. The back of the MAR dated June 2015, indicated the following regarding	R 0036	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Resident #5's physician was immediately notified by Health and Wellness Director regarding missing medications during June 2015 as a result of unavailability from pharmacy. All medications are presently onsite and being administered as ordered. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? ·The Health and Wellness Director or designee will audit the MAR, Medication Carts, and all new orders to identify residents with missing medications and to ensure MD orders are being followed appropriately daily. ·In the event other current residents are found to be missing medication, the Nurse is to follow our Missing Medication expectation guidelines. ·The Health and Wellness Director will be notified of any difficulties with this process. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?	08/03/2015

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	Levothyroxine: 6/16/15 at 6 a.m.--Unavailable from the pharmacy. 6/17/15 at 6 a.m.--Unavailable from the pharmacy. 6/18/15 at 6 a.m.--Unavailable from the pharmacy. 6/20/15 at 6 a.m.--Unavailable from the pharmacy. 6/21/15 at 6 a.m.--Unavailable from the pharmacy. 6/23/15 at 6 a.m.--Unavailable from the pharmacy. 6/24/15 at 6 a.m.--Unavailable from the pharmacy. b. A MAR dated June 2015, included, but was not limited to the following orders: 5/7/15--Mirtazapine (an antidepressant medication) 15 mg give one tablet by mouth daily at bedtime for depression. The MAR dated June 2015, indicated from 6/8/15 to 6/12/15 at 7 p.m., all the nurses initials were circled on the 7 p.m., boxes for the Mirtazapine order for a total of 5 doses of Mirtazapine were not administered. The MAR dated June 2015, indicated the following regarding Mirtazapine: 6/8/15 at 8 p.m.--The medication was not found in the medication cart.		·Nurses will be in-serviced on Missing Medication Procedure, and Brookdale's policy's on Medication Administration, and Medication Availability. ·Individual counseling will be provided to nurses that do not follow procedure. ·The Health and Wellness Director will notify the ED of any medication administration issues or concerns during morning meeting. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ·The Health and Wellness Director or designee will audit the MAR, Medication Carts, and all new orders to identify residents with missing medications and to ensure MD orders are being followed appropriately daily. ·In the event non-compliance with proper physician notification is noted, the HWD will present corrective action notices to the nurses involved. ·Such corrective action may include additional training, suspension, and up to termination of employment for repeated infractions or omissions. ·Audit findings will be provided to the Executive Director to determine if additional corrective action will be required.	

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	The resident's record lacked further documentation indicating why the resident had not received his Mirtazapine during these dates. c. A MAR dated June 2015, included, but was not limited to the following orders: 6/5/15--Albuterol (a medication used to open the bronchiole tubes in the lungs to improve breathing) 2.5 mg nebulizer treatment every four hours for 5 days. The MAR dated June 2015, indicated from 6/6/15 to 6/10/15, all the nurses initials were circled at 8 a.m., 12 p.m., 4 p.m. and 8 p.m., boxes for the Albuterol nebulizer treatment order for a total of 20 doses of Albuterol were not administered. The MAR dated June 2015, indicated the following regarding Albuterol nebulizer treatment: 6/6/15 at 8 a.m.--The Albuterol equipment was not delivered. 6/6/15 at 12 p.m.--The Albuterol equipment was not delivered. The resident's record lacked further documentation indicating why the resident had not received his Albuterol nebulizer treatment during these dates.			

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	d. A MAR dated June 2015, included, but was not limited to the following orders: 6/11/15--Protonix (a medication used to decrease the amount of acid in the stomach) 40 mg take one tablet by mouth daily. The MAR dated June 2015, indicated from 6/19/15 to 6/24/15, all the nurses initials were circled at 5 p.m., boxes for the Protonix order for a total of 6 doses of Protonix were not administered. The resident's MAR lacked documentation indicating why the resident had not received his Protonix during these dates. During an interview on 7/17/15 at 2:15 p.m., the Health Wellness Director (HWD) indicated the nurses should have contacted the physician to obtain an order for a medication to replace what was not covered by insurance or not available. A current policy titled "Medication & Treatment-General Guidelines for medication Administration/Assistance" dated 11/2011, last revised 2/3/2013, provided by the ED on 7/17/15 at 6:30 p.m., indicated "... Policy Detail: ... 23. Medications are to be given only within the parameters of the physician's orders ...			

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	27. A resident change in condition or other concerns should be communicated to the Executive Director/Nurse/designee as soon as possible for follow up action and or notification to the physician/primary care provider...."			
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure the physician's orders for medications was followed for 1 of 5 residents during the medication pass. (Resident #37) Findings include: On 7/17/15 at 8:55 a.m., Resident #37 received his medications from LPN #1. LPN #1 was observed at that time reading the Medication Administration Record (MAR) for Resident #37 and then grabbed each medication out of the cart. LPN #1 handed Resident #37 a bottle of	R 0241	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? · Health and Wellness Director notified resident #37's mail order pharmacy to confirm Ipratoprium Bromide spray was reordered. Pharmacy confirmed reorder and shipment. MD/POA notified. · Medication is currently on hand in community and being administered as ordered. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? ·The Health and Wellness	08/03/2015

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	Fluticonase (an antinflammatory) 50 micrograms (mcg) and informed him he needed to insert 2 sprays into each nostril. On 7/17/15 at 3:30 p.m., the physician's orders for all of Resident #37's medications for the month of July 2015 were reviewed. The physician's order's were as follows: 9/11/14-Fluticonase Propionate 50 mcg give 1 spray in each nostril once day as needed. 6/10/15-Ipratoprium Bromide 0.03% spray (a brochodialator medication) give 2 sprays in each nostril 2 times a day for sinusitis. The MAR for July 2015 indicated by signatures in all of the boxes for this month that the resident was given Ipratoprium Bromide 0.03% spray from 7/1/15 through 7/17/15. The MAR for July 2015, indicated by empty boxes the resident had not received Fluticonase. On 7/17/15 at 5:30 p.m., LPN #2 was observed at the medication cart which held Resident #37's medications. The Health and Wellness Director (HWD)		Director or designee will audit the MAR, Medication Carts, and all new orders to identify residents with missing medications and to ensure MD orders are being followed appropriately daily. ·In the event other current residents are found to be missing medication, the Nurse is to follow our Missing Medication expectation guidelines. ·The Health and Wellness Director will be notified of any difficulties with this process. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? ·Nurses will be in-serviced on Missing Medication Procedure, and Brookdale's policy's on Medication Administration, Medication Availability, and Medication Error. ·Individual counseling will be provided to nurses that do not follow procedure. ·The Health and Wellness Director will notify the ED of any medication administration or medication error issues or concerns during morning meeting. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ·The Health and Wellness	

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	asked LPN to help her find the nasal spray that Resident #37 received. LPN #2 went into the cart and grabbed a box of nasal spray and handed it the the HWD. The box label indicated Fluticonase prop 50 mcg give 1 spray in each nostril once daily as needed. The HWD looked at the MAR and observed all of the boxes for July 2015, for the Ipratoprium Bromide 0.03% spray were signed off and the MAR for July 2015 indicated by empty boxes, the resident had not received Fluticonase. The HWD and LPN #2 both looked through both of the medication carts and were unable to find the Ipratoprium Bromide 0.03% spray. On 7/17/15 at 5:35 p.m., LPN #2 indicated the medication she had given was the Fluticonase prop 50 mcg. On 7/17/15 at 5:40 p.m., the HWD indicated she expected the nurses to verify the right medication, right dose, right resident, right route and right time. On 7/17/15 at 6:30 p.m., the Executive Director provided the "Medications & Treatments-Medication Error Policy" Dated 3/2003 with revision dates of 5/29/2005; 10/2011 indicated,"... 7 Rights of Medication Administration include-right medication..."		Director or designee will audit the MAR, Medication Carts, and all new orders to identify residents with missing medications and to ensure MD orders are being followed appropriately daily. ·In the event non-compliance of Brookdale's Medication Error Policy is noted, the HWD will present corrective action notices to the nurses involved. ·Such corrective action may include additional training, suspension, and up to termination of employment for repeated infractions or omissions. ·Audit findings will be provided to the Executive Director to determine if additional corrective action will be required.	

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R 0272 Bldg. 00	410 IAC 16.2-5-5.1(e) Food and Nutritional Services - Deficiency (e) All food shall be served at a safe and appropriate temperature. Based on observation, interview and record review, the facility failed to ensure the food was served at the correct temperature. This deficient practice had the potential to affect 55 of 55 residents receiving food from the kitchen. Findings include: On 7/17/15 at 11:30 a.m., an observation of the kitchen was done. The menu included chicken for the alternative entree'. On 7/17/15 at 11:55 a.m., Cook #4 tested 5 chicken breasts as they came out of the oven. She placed the thermometer in the center of one chicken breast in the center of the tray and the digital thermometer read 144 degrees Fahrenheit. She placed the chicken breasts in a metal container, placed plastic wrap over them, and put it into the heated cart. On 7/17/15 at 12:25 p.m., Cook #4 tested the temperature of one of the chicken breasts before serving the residents at the	R 0272	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? ·None of the 55 residents receiving food from the kitchen suffered any adverse effects from eating he alleged undercooked food. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? ·The Health and Wellness Director and Executive Director monitored for any adverse reactions following the evening meal on 7/17/15. ·Nurses were instructed to report any flu like signs and symptoms to the HWD or ED. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? ·All dining staff was in-serviced on Brookdale's Policy "Temperature Standard for Preparation" as well as our food in service temperature log. ·The Dining Services Manager will audit the "Food in Service"	08/03/2015

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	steam table. The chicken breast was checked for the temperature with the digital temperature read 154 degrees Fahrenheit. On 7/17/15 at 5:00 p.m., the Dining Services Manager (DSM) indicated the chicken breasts at 165 degrees Fahrenheit before they were served. He indicated there was no information posted for the employees correct temperatures. On 7/17/15 at 5:10 p.m., the Dining Services Manager provided a policy in a book titled, "Temperature Standard for Preparation" dated 2005 with revision dates of 5/10 and 4/14. The policy indicated, " ...Poultry (including whole or ground chicken, turkey and duck 165 degrees Fahrenheit ...." He indicated at that time, Cook #4 should have put the chicken back into the oven to get it to the correct temperature before serving it.		HACCP Temperature Log daily x 1 week, then weekly until the alleged deficient practice does not recur. ·Individual counseling will be provided to dining staff that do not follow procedure. ·The Dining Services Manager will notify the ED of any food temperature concerns during morning meeting. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ·The Dining Services Manager will audit the “Food in Service” HACCP Temperature Log daily x 1 week, then weekly until the alleged deficient practice does not recur. ·In the event non-compliance of Brookdale’s Temperature Standard for Preparation Policy is noted, the DSM will present corrective action notices to the dining staff involved. ·Such corrective action may include additional training, suspension, and up to termination of employment for repeated infractions or omissions. ·Audit findings will be provided to the Executive Director to determine if additional corrective action will be required.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas			

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	(excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to ensure to provide sanitary conditions throughout the kitchen. This deficient practice had the potential to affect 55 of 55 of residents who received food from the kitchen. Findings include: On 7/17/15 at 11:30 a.m., the kitchen staff: Cook #3 ,Cook #4, and the Dining Services Manager (DSM) was observed preparing for the lunch service. On 7/17/15 at 11:31 a.m., the drying rack had 1 plastic tub, and 1 small metal pan that had clear spots of liquid on it. At that time, the DSM indicated there should not be any water on the dishes. On 7/17/15 at 11:32 a.m., the bottom of an oven was observed to have thick, dark debris on it. At that time, the DSM indicated the oven was cleaned weekly. On 7/17/15 at 11:34 a.m., the grill backsplash area was observed to have dark black and rust colored debris on it. At that time, the DSM indicated the grill backsplash was cleaned weekly.	R 0273	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? ·The drying rack where the plastic tub and metal pan were stacked was observed to have spots of liquid on them. The tub and pans were washed again and sanitized and placed appropriately on the shelves to allow for air drying. ·The bottom oven was observed having a dark debris on it. The oven was cleaned and all dark debris removed that evening. ·The grill backsplash was observed having dark black and rust colored debris on it. The grill was immediately cleaned and all dark debris removed. ·The dry storage area where food and condiments are stored had scattered debris under the racks. The racks were pulled and staff cleaned behind the area that evening. ·The walk in freezer had containers stacked too high on the top shelf and a tan colored debris was noted on the freezer floor. The containers were immediately lowered 18 inches beneath the freezer ceiling and the floor was cleaned. ·The ice machine was observed to have black debris on the inside hinge of the door on both sides.	08/03/2015

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	On 7/17/15 at 11:36 a.m., the dry storage area had debris on the floor. At that time, the DSM indicated the dry storage area was to be swept at the end of each shift. On 7/17/15 at 11:38 a.m., the walk in freezer had 10 pint sized containers stacked on the top shelf. The DSM indicated at that time, the ice cream should only be within 18 inches from the ceiling and it was not. There was also tan colored debris on the floor which the DSM could not identify, he indicated he was unsure of how often the freezer floor was cleaned. On 7/17/15 at 11:40 a.m., the ice machine was observed to have black debris on the inside hinge of the door on both sides. The DSM indicated he was unsure what it was. He provided an ice machine cleaning list that indicated it was cleaned on 6/29/15. The company which services the machine clean it as well and he indicated he would check on that. As of exit on 7/17/15 at 7:00 p.m., no more information had been provided. On 7/17/15 at 12:05 p.m., Cook #4 was observed with gloved hands cutting a beef roast, and there was red liquid coming out of the roast. After cutting the roast, she removed her gloves and threw		The ice machine was immediately emptied, power washed, and serviced after made aware of the alleged deficient practice. ·Two associates were observed not washing their hands for a full 20 seconds. All dining staff was in-serviced immediately on proper hand washing to prevent the spread of infection. ·Daily and weekly cleaning logs were observed to be incomplete. New daily and weekly schedules were generated and immediately implemented. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? ·All residents have the potential to be affected by the alleged deficient practices. ·The tub and pans that were observed to be wet were washed again and sanitized and placed appropriately on the shelves to allow for air drying. ·The oven was cleaned and all dark debris removed that evening. ·The grill was immediately cleaned and all dark debris removed. ·The dry storage racks were pulled and staff cleaned behind the area that evening. ·The containers stacked in the freezer were immediately lowered 18 inches beneath the freezer	

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	them away. She was observed washing her hands with soap and water for 5 seconds. On 7/17/15 at 12:09 p.m., Cook #3 was observed with gloved hands touching the oven handle, drawers, and oven mitts with food debris on them. He removed his gloves, washed his hands with soap and water for 13 seconds. He donned new gloves and was handling carrots that had been lying on the counter and wrapped them in plastic. There was a sign posted above the hand washing sink which indicated to wash hands in warm soapy water for 20 seconds. On 7/17/15 at 2:00 p.m., the DSM provided the most recent cleaning list. He indicated staff were to wash their hands for 20 seconds. The cleaning list indicated dates: 6/21/15 through 7/4/15. The daily cleaning list was blank on 6/22/15, 7/2/15, 7/3/15, and 7/4/15. The weekly deep cleaning list was blank on 6/29/15, 6/30/15, 7/1/15, 7/2/15, 7/3/15, and 7/4/15.		ceiling and the floor was cleaned. ·The ice machine was immediately emptied, power washed, and serviced after made aware of the alleged deficient practice. ·All dining staff was in-serviced immediately on proper hand washing to prevent the spread of infection. ·New daily and weekly schedules were generated and immediately implemented. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? ·All dining services staff has been inserviced on Brookdale's Food and Nutritional Services Standards and Expectations. ·Individual counseling will be provided to dining staff that do not follow procedure. ·The Director of Dining Services will notify the ED of any sanitation issues in the kitchen immediately. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ·A Dining Services Kitchen and Ice Machine Cleaning schedule has been implemented for all dining and kitchen areas. The schedules and affected areas will	

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			be audited by the DSC weekly until the alleged deficient practice does not recur. ·A dish air dry audit tool will be completed daily x 1 week and then monthly until the alleged deficient practice does not recur. ·A hand washing audit tool will be completed weekly until the alleged deficient practice does not recur. ·A food storage audit tool will be completed weekly until the alleged deficient practice does not recur. ·Results of audits will be reviewed by the Executive Director on a weekly to monthly basis to monitor for continued compliance. ·In the event a non-compliance is noted, the ED will designate next steps and monitor results.	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.			
	Based on interview and record review, the facility failed to ensure that medications were available from the Pharmacy for 2 of 5 residents whose medications were reviewed for availability from the Pharmacy. (Resident #5 and Resident #37)	R 0297	What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? ·Resident #5's physician was immediately notified by Health and Wellness Director regarding missing medications during June	08/03/2015

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	Findings include: 1. The record for Resident #5 was reviewed on 7/17/15 at 11:09 a.m. Diagnoses included, but were not limited to, depression, gastroesophageal reflux disease, hypothyroidism, and asthma. a. A MAR dated June 2015, included, but was not limited to the following orders: 5/7/15--Levothyroxine (a thyroid medication) 100 mcg (micrograms) give one tablet by mouth every morning. The MAR dated June 2015, indicated from 6/15/15 to 6/24/15 at 6 a.m., all the nurses initials were circled on the 6 a.m., boxes for the Levothyroxine order for a total of 10 doses of levothyroxine were not administered. The back of the MAR dated June 2015, indicated the following regarding Levothyroxine: 6/16/15 at 6 a.m.--Unavailable from the pharmacy. 6/17/15 at 6 a.m.--Unavailable from the pharmacy. 6/18/15 at 6 a.m.--Unavailable from the pharmacy. 6/20/15 at 6 a.m.--Unavailable from the pharmacy.		2015 as a result of unavailability from pharmacy. All medications are presently onsite and being administered as ordered ·Health and Wellness Director notified resident #37's mail order pharmacy to confirm Ipratoprium Bromide spray was reordered. Pharmacy confirmed reorder and shipment. MD/POA notified. Medication is currently on hand in community and being administered as ordered. How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken? ·The Health and Wellness Director or designee will audit the MAR, Medication Carts, and all new orders to identify residents with missing medications and to ensure MD orders are being followed appropriately daily. ·In the event other current residents are found to be missing medication, the Nurse is to follow our Missing Medication expectation guidelines. ·The Health and Wellness Director will be notified of any difficulties with this process. What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur? ·Nurses will be in-serviced on Missing Medication Procedure,	

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	6/21/15 at 6 a.m.--Unavailable from the pharmacy. 6/23/15 at 6 a.m.--Unavailable from the pharmacy. 6/24/15 at 6 a.m.--Unavailable from the pharmacy. b. A MAR dated June 2015, included, but was not limited to the following orders: 5/7/15--Mirtazapine (an antidepressant medication) 15 mg give one tablet by mouth daily at bedtime for depression. The MAR dated June 2015, indicated from 6/8/15 to 6/12/15 at 7 p.m., all the nurses initials were circled on the 7 p.m., boxes for the Mirtazapine order for a total of 5 doses of Mirtazapine were not administered. The MAR dated June 2015, indicated the following regarding Mirtazapine: 6/8/15 at 8 p.m.--The medication was not found in the medication cart. The resident's record lacked further documentation indicating why the resident had not received his Mirtazapine during these dates. c. A MAR dated June 2015, included, but was not limited to the following orders:		and Brookdale's policy's on Medication Administration, Medication Availability, and Medication Error. ·Individual counseling will be provided to nurses that do not follow procedure. ·The Health and Wellness Director will notify the ED of any medication administration or medication error issues or concerns during morning meeting. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place? ·The Health and Wellness Director or designee will audit the MAR, Medication Carts, and all new orders to identify residents with missing medications and to ensure MD orders are being followed appropriately daily. ·In the event non-compliance of Brookdale's Medication Error Policy is noted, the HWD will present corrective action notices to the nurses involved. ·Such corrective action may include additional training, suspension, and up to termination of employment for repeated infractions or omissions. ·Audit findings will be provided to the Executive Director to determine if additional corrective action will be required.	

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	6/5/15--Albuterol (a medication used to open the bronchiole tubes in the lungs to improve breathing) 2.5 mg nebulizer treatment every four hours for 5 days. The MAR dated June 2015, indicated from 6/6/15 to 6/10/15, all the nurses initials were circled at 8 a.m., 12 p.m., 4 p.m. and 8 p.m., boxes for the Albuterol nebulizer treatment order for a total of 20 doses of Albuterol were not administered. The MAR dated June 2015, indicated the following regarding Albuterol nebulizer treatment: 6/6/15 at 8 a.m.--The Albuterol equipment was not delivered. 6/6/15 at 12 p.m.--The Albuterol equipment was not delivered. The resident's record lacked further documentation indicating why the resident had not received his Albuterol nebulizer treatment during these dates. d. A MAR dated June 2015, included, but was not limited to the following orders: 6/11/15--Protonix (a medication used to decrease the amount of acid in the stomach) 40 mg take one tablet by mouth daily. The MAR dated June 2015, indicated			

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	from 6/19/15 to 6/24/15, all the nurses initials were circled at 5 p.m., boxes for the Protonix order for a total of 6 doses of Protonix were not administered. The resident's MAR lacked documentation indicating why the resident had not received his Protonix during these dates. During an interview on 7/17/15 at 2 p.m., the Administrator indicated she would have expected the nurses to let the HWD know if they were having trouble obtaining the medications from the pharmacy for this resident. During an interview on 7/17/15 at 2:15 p.m., the HWD indicated the resident did not use the facility pharmacy. She indicated he used a mail in pharmacy, but his family member would give permission at times to use the facility pharmacy when the facility had trouble obtaining medications from his mail in pharmacy. A delivery sheet from Pharmacy was requested from the Health Wellness Director (HWD) on 7/17/15 at 2:25 p.m., for the following drugs Levothyroxine, Mirtazapine, and Protonix. During an interview on 7/17/15 at 5:40			

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	p.m., the HWD indicated if a medication was circled and no explanation was on the back of the MAR, the resident had either refused the medication or the medication was unavailable. She indicated blanks with no signature indicated the medication was not given. During an interview on 7/17/15 at 6 p.m., the HWD indicated she did not find any pharmacy slips for when the following medications were delivered: Levothyroxine, Mirtazapine and Protonix. The HWD indicated she was unable to find information to indicate when the nebulizer machine was delivered to the resident. 2. On 7/17/15 at 8:55 a.m., Resident #37 was receiving his medications from LPN #1. LPN #1 was observed reading the Medication Administration Record (MAR) for Resident #37 and then she would grab each medication out of the cart. LPN #1 handed Resident #37 a bottle of Fluticonase (an antinflammatory) 50 micrograms (mcg) and informed him he needed to insert 2 sprays into each nostril. On 7/17/15 at 3:30 p.m., the physician's orders for all of Resident #37's			

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	medications for the month of July were reviewed. The physician's order's were as follows: 9/11/14-Fluticonase Propionate 50 mcg give 1 spray in each nostril once day as needed. 6/10/15-Ipratoprium Bromide 0.03% spray (a brochodialator medication) give 2 sprays in each nostril 2 times a day for sinusitis. The MAR for July 2015 indicated by signatures in all of the boxes for July that the resident was given Ipratoprium Bromide 0.03% spray give 2 sprays in each nostril 2 times a day for sinusitis from 7/1/15 through 7/17/15. The MAR for July 2015 indicated by empty boxes that the resident had not received Fluticonase. On 7/17/15 at 5:30 p.m., LPN #2 was observed at the medication cart which held Resident #37's medications. The Health and Wellness Director (HWD) asked LPN#2 to help her to find the nasal spray that Resident #37 received. LPN #2 went into the cart and grabbed a box of nasal spray and handed it the the HWD. The box label indicated Fluticonase prop 50 mcg give 1 spray in			

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	each nostril once day as needed. The HWD looked at the MAR and observed that all of the boxes for July 2015 for the Ipratoprium Bromide 0.03% spray were signed off and the MAR for July 2015 indicated by empty boxes, the resident had not received Fluticonase. The HWD and LPN #2 looked through both of the medication carts and were unable to find the Ipratoprium Bromide 0.03% spray. On 7/17/15 at 5:35 p.m., the HWD indicated she had a lot of problems with the mail order pharmacies and had been aware other resident's had not gotten their medication, but this was a new concern regarding this resident. A current pharmacy contract titled "Pharmacy Products and Services Agreement" dated 2/1/15, provided by the Executive Director (ED) on 7/17/15 at 5:40 p.m. indicated "... 1. Responsibilities of Pharmacy 1.1 General: During the term of this of this Agreement, Pharmacy shall: (a) provide Pharmacy Products to Community and its residents in a prompt and timely manner in compliance with Applicable Law and currently accepted professional standards for institutional pharmacy providers; (b) render Pharmacy Services to Community and its residents in a prompt and timely manner in accordance with Applicable			

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	Law and currently accepted professional standards for institutional pharmacy providers ... 1.2 Delivery Schedule: Pharmacy shall deliver. Pharmacy Products to Community in accordance with the delivery schedule attached hereto as Schedule 1.2. In the event Pharmacy does not make any delivery required hereunder, then Community may obtain such delivery from a different pharmacy provider, but only as to such failed delivery... Schedule 1.2 Delivery Schedule: Daily Delivery, Monday through Sunday. Pharmacy is on call twenty-four (24) hours a day for emergency services ...." A current policy titled "Medication & Treatment-General Guidelines for medication Administration/Assistance" dated 11/2011, last revised 2/3/2013, provided by the ED on 7/17/15 at 6:30 p.m., indicated "... Policy Detail: ... 23. Medications are to be given only within the parameters of the physician's orders ... 25. Documentation of medications administered/assisted should occur promptly after the resident had taken the medication. Associates should sign the MAR with their full signature/title and initial each medication administered/assisted. ...." A current policy titled "How to Order			

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	Medications" dated April 2011, provided by the ED on 7/17/15 at 6:36 p.m., indicated "Purpose: To provide guidance to associates placing orders for resident medications ... 1. Verify the resident's preferred pharmacy from the Resident Information Sheet ... 9. Contact the pharmacy by phone if the newly ordered / refilled medications do not arrive in a timely manner. 10. Notify the resident, family or contact the physician for a new order / prescription when a routine medication refill orders are depleted."			