

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155304	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/18/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF NEW CASTLE THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 N 16TH ST NEW CASTLE, IN 47362
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F000000	<p>This visit was for a Post Survey Revisit to the Investigation of Complaint IN00153582, completed on 8-6-14.</p> <p>Complaint IN00153582 -- Not corrected.</p> <p>Survey dates: September 18, 2014</p> <p>Facility number: 000201 Provider number: 155304 AIM number: 100267910</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF: 4 SNF/NF: 51 Total: 55</p> <p>Census payor type: Medicare: 13 Medicaid: 28 Other: 14 Total: 55</p> <p>Sample: 4</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or excuted in compliance with state and federal laws. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance in 10/8/2014.</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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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>A. Based on interview and record review, the facility failed to ensure a hypnotic medication was administered as ordered. This medication was administered for 5 days past the ordered 10 day time period (Resident #G)</p> <p>Findings include:</p> <p>A. Resident #G's clinical record was reviewed on 9-18-14 at 1:25 p.m. Her diagnoses included, but were not limited to, bilateral knee replacement in August, 2014.</p> <p>A physician's progress note, dated 9-2-14, indicated Resident #G had complaints of pain in the thighs keeping her awake at night. This note indicated the plan of care was to prescribe Ambien (a hypnotic medication) PRN (as needed). On 9-2-14 at 11:30 a.m., a physician telephone order for Resident #G indicated an order for Ambien 10 milligrams (mg) by mouth (po) at bedtime PRN for sleep for 10 days.</p> <p>In review of the September, 2014</p>	F000282	<p>F 282 It is the intent of this facility to ensure hypnotic medication is administered as ordered. 1. corrective action for affected resident: Resident #G's physician was notified of the medication error on 9/18/2014 with new order given. 2. Other residents with potential to be affected: Audit completed for all residents current medication orders for accuracy of start and stop dates on MAR, start/stop dates noted as needed. 3. Measures to prevent reoccurrence: Directed in-service training on 10/7/2014 for licensed nurses related to policy and procedures for Physician's Orders and Stop Orders. DON/designee to review the physician orders and MAR 3 times a week for 2 months then 2 times a week for 2 months then weekly for 2 months to ensure medication is administered per time frame as ordered. 4. Monitoring of corrective action to ensure the practice will not recur: The DON/designee will complete a monthly summary audit to be presented to the monthly QA committee with the Administrator related to medications being administered per time frame ordered. This monthly summary</p>	10/08/2014

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	<p>Medication Administration Record (MAR) for Resident #G, one of the entries indicated "Ambien 10 mg po [for] insomnia QHS [at every bedtime] x 10 day." The entry did not include an initiation date or stop date for the medication. The field for the dates did not include any dates marked off to indicate when to stop the administration upon the completion of the 10 days. The medication was indicated to have been administered 15 times between 9-3-14 at 1:30 a.m. and 9-18-14 at 12:30 a.m., including 3 doses administer between 9-14-14 and 9-18-14.</p> <p>At this same interview, the DON provided copies of the "Controlled Drug" record for Ambien 10 mg for Resident #G. The first record indicated 10 doses of the Ambien 10 mg had been delivered to the facility on 9-3-14, with no time indicated. A second delivery was indicated by a second "Controlled Drug" record to have been received on 9-11-14 for 30 doses of Ambien 10 mg for Resident #G. The DON indicated she had no idea why a second delivery would have occurred.</p> <p>On 9-18-14 at 3:58 p.m., a telephone interview was conducted with a supervisor from the facility's contracted pharmacy. He indicated the contracted</p>		will again be presented to the Quarterly QA committee with the Administrator and Medical Director. 5. Date the systematic changes will be completed and who will be responsible: DON/designee will be responsible for on-going compliance. Date of compliance 10/8/2014.				

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	<p>pharmacy had received an electronic request for a refill for Resident #G's Ambien order. He indicated upon receipt of the refill request, it was noted there were no refills available. He indicated one of the team members who deals with controlled substances contacted the resident's attending physician to request a refill. He indicated normally the pharmacy will contact both the facility and the resident's physician to request a medication refill. He indicated, "Apparently there was a communication issue in that the doctor responded very quickly to our refill request and the nursing home was not made aware of the new order."</p> <p>In an interview with the DON on 9-18-14 at 4:10 p.m., she indicated she had spoken to a supervisor at the contracted pharmacy. She indicated she was informed that someone from the facility had requested a refill of the Ambien for Resident #G.</p> <p>In an interview with the DON on 9-18-14 at 4:57 p.m., she indicated she had just spoken with Resident #G's attending physician by telephone. She indicated he provided an order to authorize the continued use of the Ambien 10 mg at bedtime as needed for an additional 30 days, to be effective as of 9-11-14. She</p>			

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F000425 SS=E	<p>acknowledged the facility staff had not taken the initiative to discover why an additional 30 doses of Ambien 10 mg had been delivered until this was brought to the facility's attention on this date in light of the order, dated 9-2-14 for a 10 day time period of use.</p> <p>In interview with the Administrator on 9-18-14 at 4:35 p.m., she indicated she could not locate any particular policy or procedure regarding how to transcribe physician orders onto the MAR.</p> <p>This deficiency was cited on 8-6-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</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</p>			

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	<p>and biologicals) to meet the needs of each 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.</p> <p>A. Based on interview and record review, the facility failed to ensure a hypnotic medication was administered as ordered. This medication was administered for 5 days past the ordered 10 day time period (Resident #G)</p> <p>B. Based on interview and record review, the facility failed to ensure a hypnotic medication was administered as ordered on an "as needed" basis, was authorized by a licensed nurse prior to administration by a qualified medication aide (QMA) for 1 of 4 residents reviewed for receipt of medications as ordered by the physician. This medication was administered 14 times by a QMA without documented prior approval of the licensed nurse. (Resident #G)</p> <p>Findings include:</p> <p>A. Resident #G's clinical record was reviewed on 9-18-14 at 1:25 p.m. Her diagnoses included, but were not limited to, bilateral knee replacement in August, 2014.</p>	F000425	<p>F425 It is the intent of this facility to ensure a hypnotic medication is administered as ordered. It is the intent of this facility to ensure a hypnotic medication is administered as ordered on an "as needed" basis, is authorized by a licensed nurse prior to administration by a qualified medication aide (QMA). 1. corrective action for affected resident: Resident #G's physician was notified of the medication error on 9/18/2014 with new order given. Policy and Procedure initiated regarding QMA administering PRN medications. 2. Other residents with potential to be affected: Audit completed for all residents current medication orders for accuracy of start and stop dates on MAR. Start/Stop dates noted as needed. Audit completed for QMA administering prn medications. IN-service completed with QMA's to obtain licensed nurse approval before administering prn medication. 3. Measures to prevent reoccurrence: Directed in-service training on 10/7/2014 for licensed nurses and QMA's related to policy and procedures for Physician's Orders and Stop</p>	10/08/2014

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	<p>A physician's progress note, dated 9-2-14, indicated Resident #G had complaints of pain in the thighs keeping her awake at night. This note indicated the plan of care was to prescribe Ambien (a hypnotic medication) PRN (as needed). On 9-2-14 at 11:30 a.m., a physician telephone order for Resident #G indicated an order for Ambien 10 milligrams (mg) by mouth (po) at bedtime PRN for sleep for 10 days.</p> <p>In review of the September, 2014 Medication Administration Record (MAR) for Resident #G, one of the entries indicated "Ambien 10 mg po [for] insomnia QHS [at every bedtime] x 10 day." The entry did not include an initiation date or stop date for the medication. The field for the dates did not include any dates marked off to indicate when to stop the administration upon the completion of the 10 days. The medication was indicated to have been administered 15 times between 9-3-14 at 1:30 a.m. and 9-18-14 at 12:30 a.m., including 3 doses administer between 9-14-14 and 9-18-14.</p> <p>At this same interview, the DON provided copies of the "Controlled Drug" record for Ambien 10 mg for Resident #G. The first record indicated 10 doses of the Ambien 10 mg had been delivered</p>		<p>Orders and PRN drug administration-qualified medication aide. DON/designee to review the physician orders and MAR record 3 times a week for 2 months then 2 times a week for 2 months then weekly for 2 months to ensure medication is administered per time frame as ordered and QMA administering prn medications only after authorization is obtained from a licensed nurse. 4. Monitoring of corrective action to ensure the practice will not recure: The DON/designee will complete a monthly summary audit to be presented to the monthly QA committee with the Administrator related to medications being administered per time frame ordered and QMA obtaining licensed nurse authorization to administer a prn medication. This monthly summary will again be presented to the Quarterly QA committee with the Administrator and Medical Director. 5. Date the systematic changes will be completed and who will be responsible: DON/designee will be responsible for on-going compliance. Date of compliance 10/8/2014.</p>		

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	<p>to the facility on 9-3-14, with no time indicated. A second delivery was indicated by a second "Controlled Drug" record to have been received on 9-11-14 for 30 doses of Ambien 10 mg for Resident #G. The DON indicated she had no idea why a second delivery would have occurred.</p> <p>On 9-18-14 at 3:58 p.m., a telephone interview was conducted with a supervisor from the facility's contracted pharmacy. He indicated the contracted pharmacy had received an electronic request for a refill for Resident #G's Ambien order. He indicated upon receipt of the refill request, it was noted there were no refills available. He indicated one of the team members who deals with controlled substances contacted the resident's attending physician to request a refill. He indicated normally the pharmacy will contact both the facility and the resident's physician to request a medication refill. He indicated, "Apparently there was a communication issue in that the doctor responded very quickly to our refill request and the nursing home was not made aware of the new order."</p> <p>In an interview with the DON on 9-18-14 at 4:10 p.m., she indicated she had spoken to a supervisor at the contracted</p>						

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	<p>pharmacy. She indicated she was informed that someone from the facility had requested a refill of the Ambien for Resident #G.</p> <p>In an interview with the DON on 9-18-14 at 4:57 p.m., she indicated she had just spoken with Resident #G's attending physician by telephone. She indicated he provided an order to authorize the continued use of the Ambien 10 mg at bedtime as needed for an additional 30 days, to be effective as of 9-11-14. She acknowledged the facility staff had not taken the initiative to discover why an additional 30 doses of Ambien 10 mg had been delivered until this was brought to the facility's attention on this date in light of the order, dated 9-2-14 for a 10 day time period of use.</p> <p>B. A. Resident #G's clinical record was reviewed on 9-18-14 at 1:25 p.m. Her diagnoses included, but were not limited to, bilateral knee replacement in August, 2014.</p> <p>A physician's progress note, dated 9-2-14, indicated Resident #G had complaints of pain in the thighs keeping her awake at night. This note indicated the plan of care was to prescribe Ambien (a hypnotic medication) PRN (as needed). On 9-2-14 at 11:30 a.m., a physician telephone order</p>						

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	<p>for Resident #G indicated an order for Ambien 10 milligrams (mg) by mouth (po) at bedtime PRN for sleep for 10 days.</p> <p>In review of the September, 2014 Medication Administration Record (MAR) for Resident #G, one of the entries indicated "Ambien 10 mg po [for] insomnia QHS [at every bedtime] x 10 day." The entry did not include an initiation date or stop date for the medication. The field for the dates did not include any dates marked off to indicate when to stop the administration upon the completion of the 10 days. The medication was indicated to have been administered 15 times between 9-3-14 at 1:30 a.m. and 9-18-14 at 12:30 a.m., including 3 doses administer between 9-14-14 and 9-18-14.</p> <p>In an interview with the Director of Nursing (DON) on 9-18-14 at 3:20 p.m. she identified the staff member's initials who had documented the administration of the Ambien. She indicated QMA #1 administered the Ambien eight times; QMA #2 administered the Ambien six times and LPN #1 administered the Ambien one time. This same information was documented on the "Controlled Drug" record for this medication. Of the 3 doses administered after 9-13-14, each</p>			

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	<p>were administered by QMA's. The DON indicated, "The QMA is supposed to get authorization from the licensed nurse prior to administering a PRN medication and [should] document or make a progress note" regarding the authorization.</p> <p>In review of the nursing progress notes and the MAR, there was a lack of documentation of authorization of prior authorization of the licensed nurse prior to administration of the PRN hypnotic medication.</p> <p>In interview with the DON on 9-18-14 at 5:01 p.m., she indicated she could not locate a facility policy regarding QMA's not administering a PRN medication without prior authorization of a licensed nurse. She indicated it was "just something we know."</p> <p>In interview with the Administrator on 9-18-14 at 4:35 p.m., she indicated she could not locate any particular policy or procedure regarding how to transcribe physician orders onto the MAR.</p> <p>The "Indiana Administrative Code," 412 IAC 2-1-9(a)(11), "Scope of Practice" for QMA's indicates a QMA may administer PRN medications "only if authorization is obtained from the facility's licensed nurse</p>			

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F000514 SS=D	<p>on duty or on call. If authorization is obtained, the QMA must:</p> <p>(A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred.</p> <p>(B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including time of contact.</p> <p>(C) Obtain permission to administer the medication each time these symptoms occur in the resident.</p> <p>(D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift or, if the nurse was on call, by the end of the nurse's next tour of duty."</p> <p>This deficiency was cited on 8-6-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-25(b)(1) 3.1-25(b)(8) 3.1-25(c) 3.1-25(e)(1)</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on</p>			

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	<p>each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>A. Based on interview and record review, the facility failed to ensure complete and accurate documentation related to a hypnotic medication for 1 of 4 residents reviewed for medication administration. (Resident #G)</p> <p>B. Based on interview and record review, the facility failed to ensure complete and accurate documentation of prior authorization by a licensed nurse before the administration of a PRN (as needed only) medication by a QMA (Qualified Medication Aide) for 1 of 4 residents reviewed for medication administration. (Resident #G)</p> <p>Findings include:</p> <p>A. Resident #G's clinical record was reviewed on 9-18-14 at 1:25 p.m. Her diagnoses included, but were not limited to, bilateral knee replacement in August, 2014.</p>	F000514	<p>F514 It is the intent of this facility to ensure complete and accurate documentation related to a hypnotic medication. It is the intent of this facility to ensure complete and accurate documentation of prior authorization by a licensed nurse before the administration of a PRN medication by a QMA. 1. Corrective action for affected resident: Resident #G's physician was notified of the medication error on 9/18/2014 with new order given. Policy and Procedure initiated regarding QMA administering PRN medications. 2. Other residents with potential to be affected: Audit completed for all residents current medication orders for accuracy of start and stop dates on MAR. Start/Stop dates noted as needed. Audit completed for QMA administering prn medications. In-service completed with QMA's to obtain licensed nurse approval before administering prn medication. 3. Measures to prevent</p>	10/08/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A physician's progress note, dated 9-2-14, indicated Resident #G had complaints of pain in the thighs keeping her awake at night. This note indicated the plan of care was to prescribe Ambien (a hypnotic medication) PRN (as needed). On 9-2-14 at 11:30 a.m., a physician telephone order for Resident #G indicated an order for Ambien 10 milligrams (mg) by mouth (po) at bedtime PRN for sleep for 10 days.</p> <p>In review of the September, 2014 Medication Administration Record (MAR) for Resident #G, one of the entries indicated "Ambien 10 mg po [for] insomnia QHS [at every bedtime] x 10 day." The entry did not include an initiation date or stop date for the medication. The field for the dates did not include any dates marked off to indicate when to stop the administration upon the completion of the 10 days. The medication was indicated to have been administered 15 times between 9-3-14 at 1:30 a.m. and 9-18-14 at 12:30 a.m., including 3 doses administer between 9-14-14 and 9-18-14.</p> <p>At this same interview, the DON provided copies of the "Controlled Drug" record for Ambien 10 mg for Resident #G. The first record indicated 10 doses</p>		<p>reoccurrence: Directed in-service training on 10/7/2014 for licensed nurses and QMA's related to policy and procedures for Physician's Orders and Stop Orders and PRN drug administration-qualified medication aide. DON/designee to review the physicaian orders and MAR record 3 times a week for 2 months then 2 times a week for 2 months then weekly for 2 months to ensure medication is administered per time frame as ordered and QMA administering prn medications only after authorization is obtained from a licensed nurse. 4. Monitoring of corrective action to ensure the practice will not recur: The DON/designee will complete a monthly summary audit to be presented to the monthly QA committee with the Administrator related to medications being administered per time frame ordered and QMA obtaining licensed nurse authorization to administer a prn medication. This monthly summary will again be presented to the Quarterly QA committee with the Administrator and Medical Director. 5. Date the systematic changes will be completed and who will be responsible: DON/designee will be responsible for on-going compliance. Date of compliance 10/8/2014.</p>	

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	<p>of the Ambien 10 mg had been delivered to the facility on 9-3-14, with no time indicated. A second delivery was indicated by a second "Controlled Drug" record to have been received on 9-11-14 for 30 doses of Ambien 10 mg for Resident #G. The DON indicated she had no idea why a second delivery would have occurred.</p> <p>On 9-18-14 at 3:58 p.m., a telephone interview was conducted with a supervisor from the facility's contracted pharmacy. He indicated the contracted pharmacy had received an electronic request for a refill for Resident #G's Ambien order. He indicated upon receipt of the refill request, it was noted there were no refills available. He indicated one of the team members who deals with controlled substances contacted the resident's attending physician to request a refill. He indicated normally the pharmacy will contact both the facility and the resident's physician to request a medication refill. He indicated, "Apparently there was a communication issue in that the doctor responded very quickly to our refill request and the nursing home was not made aware of the new order."</p> <p>In an interview with the DON on 9-18-14 at 4:10 p.m., she indicated she had</p>			

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	<p>spoken to a supervisor at the contracted pharmacy. She indicated she was informed that someone from the facility had requested a refill of the Ambien for Resident #G.</p> <p>In an interview with the DON on 9-18-14 at 4:57 p.m., she indicated she had just spoken with Resident #G's attending physician by telephone. She indicated he provided an order to authorize the continued use of the Ambien 10 mg at bedtime as needed for an additional 30 days, to be effective as of 9-11-14. She acknowledged the facility staff had not taken the initiative to discover why an additional 30 doses of Ambien 10 mg had been delivered until this was brought to the facility's attention on this date in light of the order, dated 9-2-14 for a 10 day time period of use.</p> <p>B. A. Resident #G's clinical record was reviewed on 9-18-14 at 1:25 p.m. Her diagnoses included, but were not limited to, bilateral knee replacement in August, 2014.</p> <p>A physician's progress note, dated 9-2-14, indicated Resident #G had complaints of pain in the thighs keeping her awake at night. This note indicated the plan of care was to prescribe Ambien (a hypnotic medication) PRN (as needed). On 9-2-14</p>						

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	<p>at 11:30 a.m., a physician telephone order for Resident #G indicated an order for Ambien 10 milligrams (mg) by mouth (po) at bedtime PRN for sleep for 10 days.</p> <p>In review of the September, 2014 Medication Administration Record (MAR) for Resident #G, one of the entries indicated "Ambien 10 mg po [for] insomnia QHS [at every bedtime] x 10 day." The entry did not include an initiation date or stop date for the medication. The field for the dates did not include any dates marked off to indicate when to stop the administration upon the completion of the 10 days. The medication was indicated to have been administered 15 times between 9-3-14 at 1:30 a.m. and 9-18-14 at 12:30 a.m., including 3 doses administer between 9-14-14 and 9-18-14.</p> <p>In an interview with the Director of Nursing (DON) on 9-18-14 at 3:20 p.m. she identified the staff member's initials who had documented the administration of the Ambien. She indicated QMA #1 administered the Ambien eight times; QMA #2 administered the Ambien six times and LPN #1 administered the Ambien one time. This same information was documented on the "Controlled Drug" record for this medication. Of the</p>						

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	<p>3 doses administered after 9-13-14, each were administered by QMA's. The DON indicated, "The QMA is supposed to get authorization from the licensed nurse prior to administering a PRN medication and [should] document or make a progress note" regarding the authorization.</p> <p>In review of the nursing progress notes and the MAR, there was a lack of documentation of authorization of prior authorization of the licensed nurse prior to administration of the PRN hypnotic medication.</p> <p>In interview with the DON on 9-18-14 at 5:01 p.m., she indicated she could not locate a facility policy regarding QMA's not administering a PRN medication without prior authorization of a licensed nurse. She indicated it was "just something we know."</p> <p>In interview with the Administrator on 9-18-14 at 4:35 p.m., she indicated she could not locate any particular policy or procedure regarding how to transcribe physician orders onto the MAR.</p> <p>The "Indiana Administrative Code," 412 IAC 2-1-9(a)(11), "Scope of Practice" for QMA's indicates a QMA may administer PRN medications "only if authorization is</p>			

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	<p>obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must:</p> <p>(A) Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred.</p> <p>(B) Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including time of contact.</p> <p>(C) Obtain permission to administer the medication each time these symptoms occur in the resident.</p> <p>(D) Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift or, if the nurse was on call, by the end of the nurse's next tour of duty."</p> <p>This deficiency was cited on 8-6-14. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				