

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/15/2014
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NAME OF PROVIDER OR SUPPLIER  GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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R000000	<p>This visit was for the Investigation of Complaint IN00156360.</p> <p>Complaint IN00156360- Substantiated. State deficiency related to the allegations is cited at R0241.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: October 14 and 15, 2014</p> <p>Facility number: 011187 Provider number: 155759 AIM number: 200838150</p> <p>Survey team: Penny Marlatt, RN, TC</p> <p>Census bed type: SNF: 23 SNF/NF: 26 Residential: 33 Total: 82</p> <p>Census payor type: Medicare: 18 Medicaid: 25 Other: 6 Total: 82</p> <p>Sample: 3</p> <p>These State findings are cited in</p>	R000000	<p>Preparation or execution of this plan of correction does not constitute provider admission or agreement related to the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of State Law. The Plan of Correction is submitted in order to respond to the allegation of offense and noncompliance cited during Indiana State Department of Health Complaint Survey on October 15th, 2014. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</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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R000241	<p>accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on October 20, 2014 by Cheryl Fielden, RN.</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 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 interview and record review, the facility failed to ensure medications were administered as ordered by the physician for 2 of 3 residents. This deficient practice has the potential to cause adverse effects to the resident. (Resident #A and #B)</p> <p>Findings include:</p> <p>A. Resident #A's clinical record was reviewed on 10-14-14 at 10:10 a.m. Her diagnoses included, but were not limited to, Alzheimer's disease, dementia, depression and diabetes.</p> <p>In review of a nursing progress note, dated 10-8-14, it indicated a medication</p>	R000241	<p><b><u>R241 Health Services</u> - What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b> Corrections in the Medication Administration Record (MAR) to reflect the correct dosage and timing were completed for Resident A on 10/08/2014. Corrections in the MAR to reflect the correct dosage and timing were completed for Resident B on 10/15/2014.</p> <p><b>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.</b> The monthly MAR Rewrites were reconciled with Physician Orders on 11/01/2014 to ensure</p>	11/14/2014

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	<p>error had been identified that date in regard to an order for Namenda IR 10 mg twice daily from 9-24-14. It indicated it was observed in the MAR (medication administration record) the resident had only been receiving the medication once daily in the morning since 9-26-14. It indicated the resident had displayed no adverse effects or increase in behaviors. The clinical record indicated the physician and family had been notified of the error, as well as correction made in the MAR to reflect the correct dosage and timing and staff counseled in regard to the medication error.</p> <p>B. Resident #B's clinical record was reviewed on 10-14-14 at 3:25 p.m. Her diagnoses included, but were not limited to, hip fracture in May, 2014, Alzheimer's disease, depression and history of weight loss.</p> <p>In review of a "Note To Attending Physician/Prescriber" from the facility's consulting Pharmacist, dated 8-19-14, it indicated, "Current FDA dose recommendations (released in September 2011) state that the maximum dose [for Celexa/citalopram] should not exceed 40 mg [milligrams] for any patient, and not over 20 mg daily for patients over age 60...I recommend to reduce this resident's dose to 20 mg daily per above</p>		<p>accuracy and completeness. The monthly MAR Rewrites will be reconciled with Physician Orders on a monthly basis thereafter to ensure accuracy and completeness. Medical Records are reconciled by the Director of Health Services (DHS) or designee. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b> Education will be presented to Registered Nurses, Licensed Practical Nurses, and Qualified Medication Assistants on the topic of "Guidelines for Medication Orders" (Attachment A) and "Medication Orders." (Attachment B) As outlined in the policy, the prescriber is contacted to verify or clarify an order to correct issues related to MAR's, reconciliation, rewrites, telephone orders, pharmacy notes to physician prescriber, medication errors, and dose reductions. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b> Physician Telephone Orders, Consultant Pharmacist Notes to Physician Prescriber, MAR's rewrites, reconciliation, medication errors, and dose reduction will be audited by the Director of Health Services or designee two (2) times per week for four (4) weeks then monthly for five (5) months to ensure</p>				

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	<p>guidelines." A response from the attending physician, dated 8-24-14 indicated to discontinue the current dose of Celexa 40 mg and to change it to "Celexa 20 mg po [by mouth] q-day [daily]." A handwritten notation, dated 8-25-14 and signed by LPN #1, indicated "Res. [resident] is currently taking Celexa 20 mg daily."</p> <p>In review of the recapitulation orders for admission on 8-12-14 through October, 2014, it indicated the resident was physician-ordered for citalopram 20 mg twice daily by mouth. In review of the MAR for the same time period, it indicated the medication had been administered twice daily, upon rising in the morning and at bedtime, through the morning dose of 10-14-14.</p> <p>In review of the telephone orders received by licensed nurses from prescribers, there were two telephone orders that were voided regarding the Celexa. The first one indicated, "DC [discontinue] Celexa 40 mg. [Sign for change] Celexa 20 mg." This form had a diagonal mark through the written information and a notation of "Rewritten." This order form had no date, no resident name, no signature of the person writing the order. A second telephone order form, identified for</p>		<p>compliance. The results of the written audit observations (Attachment C) will be reported, reviewed and trended for compliance through the campus Quality Assurance Committee for a minimum of 6 months. A Medication Error Rate threshold greater than 0% will determine the need for further monitoring, random monitoring, or completion of monitoring.</p>				

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R000409	<p>Resident #B, dated 8-25-14 at 1:50 p.m. and signed by LPN #1 indicated, "DC Celexa 40 mg. N.O. [new order for] Celexa 20 mg po dly [daily]" This form also had a diagonal mark through the written information and a handwritten notation which indicated "ERROR (currently on prescribed dose)".</p> <p>This Residential tag relates to Complaint IN00156360.</p> <p>5.2-4(e)</p> <p>410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter.</p> <p>Based on interview and record review, the facility failed to ensure timeliness of annual Mantoux testing and/or risk assessment for Tuberculosis (TB), for 1 of 3 residents reviewed for Mantoux testing. (Resident #C)</p> <p>Findings include:</p> <p>Resident #C's clinical record was reviewed on 10-15-14 at 8:35 a.m. It</p>	R000409	<p><b><u>R409 Infection Control</u></b></p> <p>-</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Mantoux testing was completed</p>	11/14/2014

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	<p>indicated he was admitted to the facility on 6-2-13. It indicated he received the admission 2-step Mantoux testing on 6-2-13 and 6-16-13. There was no further indication of testing or risk assessment since those dates.</p> <p>In interview with LPN #2 on 10-15-14 at 11:10 a.m., she indicated Resident #C was one of the residents who was not able to receive his annual TB testing due to supply shortages of the Mantoux solution. She indicated she was in the process of getting all residents current for their TB testing. She indicated she is responsible "for doing all the TB tests [to residents.]" She indicated she had not conducted a risk assessment for TB for Resident #C in June, 2014 when his annual TB test/screening was due.</p> <p>In interview with the Director of Nursing on 10-15-14 at 12:50 p.m., she indicated LPN #2 is responsible for tracking of residents who are due for TB testing and for getting this information to the nursing units for the nurses on those units to administer the TB testing and/or risk assessments in a timely manner. She indicated LPN #2 is not necessarily responsible for the actual administration of all TB testing, just the tracking. She indicated the administration of the actual testing and/or risk assessments is a shared</p>		<p>for Resident C on 10/15/2014.</p> <p><b>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.</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice. The Immunization Record for each resident was reviewed 11/05/2014. TB Testing and Screening will be completed as outlined in "Guidelines for TB Results Documentation: Residents." (Attachment D) The Director of Health Services or designee will complete the review.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</b></p> <p>Education will be presented to nursing administration and medical records staff on guidelines for: i)Supervisory Responsibility of the Tuberculosis Control (TB) Programs; ii) TB</p>		

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	<p>responsibility of the nursing staff.</p> <p>On 9-23-13, the Indiana State Department of Health (ISDH) provided recommendations via the "ISDH Long Term Care Newsletter", Issue 2013-20. These recommendations indicated, "Since tuberculin is not available, the following will be accepted in the interim of the shortage for employees [or current residents] with a prior negative TB screening test result: an IGRA [Interferon Gamma Release Assay] blood test or a TB Risk Assessment Questionnaire." The recommendations indicated, for facility residents, the questionnaire could be self-reported or completed by facility staff. On 9-8-14, ISDH released another newsletter which indicated the guidelines regarding the tuberculin shortage were rescinded, effective as of 9-5-14. In this newsletter, it indicated "Do not perform testing immediately in order to 'catch up.' Begin any required testing at the next due date." This information was retrieved on 10-15-14 from the ISDH's Long Term Care web site.</p> <p>5-12(d)</p>		<p>Results Summary Documentation: Residents. (Attachment E)</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur.</b></p> <p>An audit of ten (10) Immunization Records will be completed weekly by the Director of Health Services or designee for four (4) weeks then monthly for five (5) months to ensure compliance. The written results of the audit observations (Attachment F) will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation. An audit identifying any error in Immunization Records will determine the need for further monitoring, random monitoring, or completion of monitoring.</p>		