

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 05/21/2012
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NAME OF PROVIDER OR SUPPLIER WELLINGTON AT KOKOMO THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 S DIXON RD KOKOMO, IN 46902
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R0000	<p>This visit was for the Investigation of Complaints IN00108393 and IN00108495.</p> <p>Complaint IN00108393 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00108495 - Substantiated, state residential findings related to the allegations are cited at R0117 and R0241.</p> <p>Survey dates: May 17, 18, and 21, 2012</p> <p>Facility number: 011366 Provider number: 011366 AIM number: N/A</p> <p>Survey team: DeAnn Mankell, RN.- TC.</p> <p>Census bed type: Residential: 32 Total: 32</p> <p>Census payor type: Other: 32 Total: 32</p> <p>Sample: 13</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p>	R0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on May 24, 2012 by Bev Faulkner, RN				

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R0117	<p>410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on record review and interview, the facility failed to ensure QMAs (Qualified Medication Aide) were following the facility job description and the standard of practice for 2 of 3 QMA's. (QMA #1 and QMA #2). This affected 1 of 4 residents reviewed for treatments. (Resident H)</p> <p>Finding included:</p> <p>1. Resident H's clinical record was</p>	R0117	<p>Tag: R117 Personnel <u>Corrective Action</u> QMA's are no longer allowed to treat Stage 2 areas or skin tears. QMA's will only be allowed to treat intact skin only. QMA's will only be allowed to apply lotions, creams, emollients, and powders as ordered. This went into effect May 18,</p>	06/30/2012
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	<p>reviewed on 5/18/12 at 11:35 A.M.</p> <p>Resident H's diagnosis included, but were not limited to, Alzheimer's dementia.</p> <p>Review of the hospice notes indicated the resident had a pressure ulcer on her coccyx on 5/9/2012. This was staged as a Stage 2. The pressure ulcer was healing and was being treated by the hospice nurse with Duoderm dressing. The orders for the dressing were to have the dressing changed by the hospice nurse every 5 days.</p> <p>According to the care notes QMA #1 changed the Duoderm on 5/6/2012 and QMA #2 changed the Duoderm on 5/13/12.</p> <p>Review of the job description for the QMA provided by the DON (Director of Nurses) on 5/18/12 at 3:00 P.M., indicated "B. Perform treatments as assigned: 1. Perform various treatments not requiring license nurse, such as soaks or topical skin treatments to intact skin areas...."</p> <p>Review of the state law 412 IAC 2-1-9 for the scope of practice for a QMA indicated: "Sec. 9. (a) The following tasks are within the scope of practice for the QMA unless</p>		<p>2012.</p> <p><u>In-services will include</u></p> <p>Review of QMA and LPN job descriptions by June 15, 2012. The Director of Nursing will review and revise current Medication Administration Policy to reflect that QMA's are to treat intact skin only. The policy will be reviewed and approved by the Reflections Memory Care Medical Director by June 30, 2012.</p> <p><u>Systemic Measures</u></p> <p>Director of Nursing will ensure that QMA's will treat intact skin only. Nurses will be assigned to treat all skin tears and Stage 2 areas. Nurses and QMA's who violate the Policy will receive a verbal counseling on the first offense. If future offenses occur, the disciplinary process will be followed with the understanding that future disciplinary actions could</p>				

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	<p>prohibited by facility policy.... (12) Apply topical medication to minor skin conditions such as dermatitis, scabies, pediculosis, fungal-infection, psoriasis, eczema, first degree burn, or stage one decubitus ulcer...(b) The following tasks shall not be included in the QMA scope of practice: (6) Administer a treatment that involves advanced skin conditions, including stage II, III and IV decubitus ulcers."</p> <p>During an interview with the DON on 5/21/2012 at 10:00 A.M., she indicated she was unaware the QMA's could not change the dressing to a Stage 2 pressure ulcer.</p> <p>This state residential tag refers to complaint IN00108495.</p>		include up to and including possible termination. Director of Nursing will monitor treatments 3 times weekly thru next 30 days and then weekly until next annual review.				

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R0241	<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 record review and interview, the facility failed to follow their medication administration policy resulting in a resident, who did not have an order for insulin, being administered an injection of insulin for 1 of 1 resident receiving the wrong medication (Resident I).</p> <p>Findings include:</p> <p>1. Resident I's clinical record was reviewed on 5/17/12 at 11:35 A.M.</p> <p>Resident I's diagnoses included, but were not limited to dementia and osteoarthritis.</p> <p>Review of a state reportable, provided by the facility and dated 3/3/2012, indicated that Resident I was administered insulin that was ordered for Resident J.</p> <p>The care notes for 3/3/12 indicated there were no ill effects from the insulin injection. The care notes lacked any indication of the amount of insulin injected or the time of the injection.</p>	R0241	<p>Tag: R 241 Health Services Corrective Action The Director of Nursing will hold an in-service with LPN's, RN's, and QMA's on the 6 rights of medication administration to include listed below: 1. Right Resident. 2. Right Time 3. Right Medication 4. Right Dose 5. Right Route 6. Documentation The in-service will be completed by June 30, 2012. Nurses and QMA's who do not follow the six rights of medication administration will be subject to the disciplinary process. Systemic Measure The Director of Nursing held an in-service on May 17, 2012 regarding A Successful Med Pass. This in-service included the Six Rights of Medication Administration and The Six Parts of a Medication Order. Six Rights of Medication Administration included: 1. Right resident 2. Right time 3. Right medication 4. Right dose 5. Right route 6. Documentation Six Pars of a Medication Order Covered: 1. Clients full name 2. Medication 3. Dose 4. Route 5. Date Revised POC - Submitted 6/11/12</p> <p>Tag: R 241 Health Services</p>	06/30/2012			

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	<p>Review of Resident J's orders, indicated an order for "Levemir 100 units, give 20 units in the morning. When the medication error was discovered on the same day, the physician was called and orders were given to check Resident I's blood sugar every 2 hours and to give the resident extra carbohydrates to eat. There were blood sugar checks charted on 3/5/12 of 109 to 140 mg/dl.</p> <p>Review of the incident record indicated this medication error occurred on 3/3/12 at 9:30 A.M.</p> <p>Review of the undated policy for the "Administration of Medications" provided by the facility on 5/18/2012 at 3:30 P.M., the licensed nurse and the QMA (Qualified Medication Aide) are to "1. Always adhere to the five rights of medication administration, right drug, right resident, right dose, right time, right route, plus right documentation."</p> <p>During an interview with the Director of the Unit, on 5/17/12 at 11:46 A.M., she indicated the LPN who had made the medication error was given a disciplinary notice for making this medication error and two staff have to check the correct insulin and the correct resident before insulin is given in the future.</p>		<p><u>Corrective Action</u></p> <p>The Director of Nursing with the oversight of the Memory Care Director will revise current Medication Administration Policy. The revised Policy will be dated and a documentation component will be added. The nurse must document in resident's medical record the omissions of which specific of the Six Rights of Medication is in error. The Policy will be reviewed and approved by the Reflections Memory Care Medical Director by June 30, 2012. In addition, the medication errors identified by our Medication Administration Policy will be reviewed at our next Quality Assurance Committee meeting to be held on Friday, July 27, 2012. The review of medication errors will become a standard agenda item for our Quality Assurance Committee moving forward.</p>				

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	This state residential tag refers to Complaint IN00108495.		<p style="text-align: center;"><u>Six Rights of Medication.</u></p> <ol style="list-style-type: none"> 1. Right Resident 2. Right Time 3. Right Medication 4. Right Dose 5. Right Route 6. Documentation <p><u>Systemic Measure</u></p> <p>When this medication error occurred on March 3, 2012, the Director of Nursing placed in effect that two nursing personnel will be present to ensure the correct resident receives the correct medication. This measure remains in place to date and will continue until the end of the 3rd quarter 2012. Once the in-service is completed on June 12, 2012, any nurse who fails to follow the revised medication administration policy will receive disciplinary action.</p>		

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			<p>The Director of Nursing will complete or will assign a nurse to complete weekly medication administration and insulin audits to ensure ongoing compliance. The audits will remain ongoing until our next annual survey.</p> <p>The Director of Nursing held an in-service on May 17, 2012 regarding A Successful Med Pass. This in-service included the Six Rights of Medication Administration and The Six Parts of a Medication Order.</p> <p><u>Six Rights of Medication Administration included:</u></p> <p>-</p> <ol style="list-style-type: none"> 1. Right Resident 2. Right Time 3. Right Medication 4. Right Dose 5. Right Route 6. Documentation <p>Six Pars of a Medication Order</p>				

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			<p>Covered:</p> <ol style="list-style-type: none"> 1. Clients Full Name 2. Medication 3. Dose 4. Route 5. Date 6. Physicians Signature. 	
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