

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 03/25/2014
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NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN 46360
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R000000	<p>This visit was for a State Residential Licensure Survey. This visit included the investigation of Complaint IN00142040.</p> <p>Complaint IN00142040-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: March 24 & 25, 2014</p> <p>Facility number: 012180 Provider number: 012180 AIM number: N/A</p> <p>Survey team: Heather Tuttle, R.N-T.C. Lara Richards, R.N. Yolanda Love, R.N.</p> <p>Census bed type: Residential: 123 Total:123</p> <p>Census payor type: Other: 123 Total: 123</p> <p>Sample: 11</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p>	R000000	To whom it may concern:Re: event ID W56T11Please accept this Plan of Correction as our credible allegation for the Event ID above.Respectfully,Debbie Tanksley	
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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 March 31, 2014, by Janelyn Kulik, RN.			
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R000241	<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 observation, record review and interview, the facility failed to ensure medications were administered as ordered related to sliding scale insulin coverage. The facility also failed to ensure metered dose inhalers were administered per the manufacturer guidelines for 2 of 9 records reviewed. (Residents #5 and #9)</p> <p>Findings include:</p> <p>1. The record for Resident #5 was reviewed on 3/24/14 at 10:55 a.m. The resident's diagnosis included, but was not limited to, diabetes.</p> <p>A Physician's order dated 12/30/11 and listed on the March 2014 Physician's order summary (POS), indicated the resident had an order for sliding scale Humulin Regular (a type of insulin) before meals and at bedtime. The resident was to receive the following dose of insulin based on his blood sugar results:</p>	R000241	To whom it may concern,Please accept this as our credible allegation for Event ID W56T11.Respectfully,Debbie Tanksley FHAR 0241I. The corrective action for residents found to be affected by the deficient practice will be Education and In-servicing of nursing staff on the proper administration related to the Sliding Scale insulin coverage and the Metered dose administration of the inhalers.II. The facility will Identify other residents having the potential to be affected by the deficient practice by auditing all charts to Identify all insulin dependant diabetics and all residents using inhalers to ensure no others residents have been affected by the deficient practice. III. The measures and systemic changes the facility will make to ensure that the deficient practice does not recur will be as follows: The Resident Care Director and/or designee will audit daily for one month. After one month they will audit weekly for four weeks. The audits will continue for five	04/26/2014			

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	<p>150-199=1 unit 200-249=2 units 250-299=3 units 300-349=4 units Over 349=5 units</p> <p>Review of the January 2014 Medication Administration Record (MAR), indicated the resident's blood sugar on 1/4/14 at noon was 229. The resident received 3 units of insulin rather than the prescribed 2 units. On 1/5/14 at noon, the resident's blood sugar was 240. Again, the resident received 3 units of insulin rather than the prescribed 2 units.</p> <p>Review of the March 2014 MAR, indicated the resident's blood sugar was 340 when his PM blood sugar was checked on 3/4/14. The resident received 5 units of insulin rather than the ordered 4 units. On 3/8/14, the resident's PM blood sugar was 215. The resident received 5 units of insulin rather than the ordered 2 units. There was no documentation of a night time blood sugar on 3/21/14.</p> <p>Interview with the Resident Care Coordinator on 3/25/14 at 11:00 a.m., indicated the sliding scale insulin coverage was not given as ordered</p>		<p>months on a monthly basis. Then we will continue to audit randomly thereafter to ensure proper administration related to the Sliding Scale insulin coverage and the Metered Dose administration of the inhalers including following the Doctor's orders is correct. These audits will be signed off by the Administrator as well.IV. How the corrective actions will be monitored to ensure the deficient practice will not recur will be Resident Care Director and/or designee to conduct and sign the audit sign off sheets along with the Administrators signature to ensure Audits are completed as mentioned above. The Education and In-servising will be reviewed with nursing staff after 3 months of the systemic changes completion date.V. The date the systemic changes will be competed is 4-26-14.</p>				

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	and there was no documentation of the resident's blood sugar on 3/21/14 at bed time.			
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R000241	<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. 2. On 3/25/14 at 8:50 a.m., QMA #1 was observed preparing medications for Resident #9. At that time, she removed from the medication drawer a Spiriva inhaler and placed the capsule (contents) into the inhaler. She then removed a Symbicort 160 micrograms (mcg) metered dose inhaler from the medication cart. She indicated at the time, the resident has two inhalers in which he administers himself. The QMA walked into the resident's room and administered his oral medications first. At 8:53 a.m., she handed the resident the Symbicort inhaler. The resident took the inhaler, placed it into his mouth and inhaled deeply while pressing down on the inhaler. Within seconds he took another deep breath and pressed down on the inhaler. He did not wait a full minute in between inhalations. The QMA did not instruct the resident to wait a full minute, nor did she or the resident shake the contents of the inhaler prior to administration.</p>	R000241	To whom it may concern,Please accept this as our credible allegation for Event ID W56T11.Respectfully,Debbie Tanksley FHAR 0241I. The corrective action for residents found to be affected by the deficient practice will be Education and In-servicing of nursing staff on the proper administration related to the Sliding Scale insulin coverage and the Metered dose administration of the inhalers.II. The facility will Identify other residents having the potential to be affected by the deficient practice by auditing all charts to Identify all insulin dependant diabetics and all residents using inhalers to ensure no others residents have been affected by the deficient practice. III. The measures and systemic changes the facility will make to ensure that the deficient practice does not recur will be as follows: The Resident Care Director and/or designee will audit daily for one month. After one month they will audit weekly for four weeks. The audits will continue for five	04/26/2014			

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	<p>Interview with QMA #1 on 3/25/14 at 8:57 a.m., indicated she was aware the resident was supposed to wait a full minute in between inhalations and the contents of the inhaler was to be shaken prior to administration.</p> <p>The record for Resident #9 was reviewed on 3/25/14 at 9:00 a.m.</p> <p>Review of the Physician Orders on the current March 2014 recap indicated Symbicort inhaler 160 mcg two puffs twice daily.</p> <p>Interview with the Resident Care Coordinator on 3/25/14, at 10:30 a.m., indicated the facility did not have a policy regarding metered dose inhaler administration.</p> <p>Review of the 12th Edition Geriatric Dosage Handbook indicated "the inhaler should be shaken well immediately prior to use. While activating inhaler, deep breathe for 3-5 seconds, hold breath for 10 seconds and allow greater than or equal to one minute between inhalations."</p>		<p>months on a monthly basis. Then we will continue to audit randomly thereafter to ensure proper administration related to the Sliding Scale insulin coverage and the Metered Dose administration of the inhalers including following the Doctor's orders is correct. These audits will be signed off by the Administrator as well.IV. How the corrective actions will be monitored to ensure the deficient practice will not recur will be Resident Care Director and/or designee to conduct and sign the audit sign off sheets along with the Administrators signature to ensure Audits are completed as mentioned above. The Education and In-servising will be reviewed with nursing staff after 3 months of the systemic changes completion date.V. The date the systemic changes will be competed is 4-26-14.</p>				

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R000349	<p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to the indication for the use of anti psychotic and anti anxiety medications and documentation of interventions completed prior to administering an as needed (prn) anti psychotic and anti anxiety medication for 2 of 9 records reviewed. (Residents #4 and #5)</p> <p>Findings include:</p> <p>1. The record for Resident #4 was reviewed on 3/24/14 at 1:35 p.m. The resident's diagnoses included, but were not limited to, dementia and insomnia.</p> <p>A Physician's order dated 8/26/13 and listed on the March 2014 Physician's order summary (POS), indicated the resident was to receive</p>	R000349	R 349I. The corrective action for residents found to be affected by the deficient practice will be to audit all charts to ensure physicians order indicate the use for anti psychotic and anti anxiety medications and to ensure proper documentation of all interventions prior to giving the PRN medication to ensure deficient practice does not recur. Nursing staff will be In-serviced and educated to ensure proper behavior/intervention PRN Guidelines are followed for all residents. II. All charts will be audited to Identify any residents who have the potential to be affected by the deficient practice. Any resident being affected by the deficient practice will be corrected through our audits and ensuring physicians order indicate the use for PRN anti psycotic and anti anxiety medication and proper documentaion of intervention is recorded and correct.III. The measures and systemic changes the facility will make to ensure the	04/26/2014			

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	<p>Lorazepam (an anti anxiety medication) 1 milligram (mg) by mouth every 6 hours as needed (prn). There was no indication as to what condition the medication was to be used for.</p> <p>Review of the January 2014 Medication Administration Record (MAR), indicated the resident received the prn Lorazepam on the following dates:</p> <p>1/16/14 at 7:40 p.m. 1/17/14 at 6:00 p.m. 1/19/14 at 1:30 p.m. and 7:30 p.m. 1/21/14 at 7:00 p.m. 1/23/14 at 8:00 p.m. 1/28/14 at 6:00 p.m.</p> <p>The documentation on the back of the MAR, indicated the medication was given for increased restlessness and anxiety. There was no documentation of interventions attempted prior to giving the medication.</p> <p>Review of the February 2014 MAR, indicated the resident received the prn Lorazepam on the following dates:</p> <p>2/6/14 at 2:00 p.m. at 7:50 p.m. 2/10/14 at 1:30 a.m.</p>		<p>deficient practice will not recur will be to introduce a new Behavior/Intervention Flow Record that will be kept in the chart along with the medication administration record binder. (Please see attached.)IV. The Resident Care Director and/or designee will audit and monitor the Behavior/Intervention Flow Record to ensure the deficient practice does not recur. The Resident Care Director and/or designee will audit daily for one month then weekly for four weeks. Then we will continue to audit for 5 months and randomly thereafter. The Administrator will sign off indicating monitoring as well.V. The date the systemic changes will be completed is 4-26-14.</p>		

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	<p>2/11/13 at 3:30 p.m. 2/13/14 at 9:30 a.m. and 5:10 p.m. 2/17/14 at 12:00 a.m. and 4:00 p.m. 2/18/14 at 6:30 p.m. 2/20/14 at 4:00 p.m. 2/28/14 at 4:00 p.m.</p> <p>The documentation on the back of the MAR, indicated the medication was given for increased restlessness and anxiety. There was no documentation of interventions attempted prior to giving the medication.</p> <p>Review of the March 2014 MAR, indicated the resident received the prn Lorazepam on the following dates:</p> <p>3/1/14 at 1:00 a.m. 3/13/14 at 4:10 p.m. 3/18/14 at 2:00 p.m. and 8:25 p.m. 3/19/14 at 6:00 p.m. 3/20/14 at 4:00 p.m.</p> <p>The documentation on the back of the MAR, indicated the medication was given for increased restlessness and anxiety. There was no documentation of interventions attempted prior to giving the medication.</p>						

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	<p>Interview with the Memory Care Director on 3/25/14 at 10:45 a.m., indicated prior to giving the resident her prn Lorazepam, they try to redirect the resident. She indicated none of this was documented on the back of the MAR nor in the Nursing progress notes.</p> <p>2. The record for Resident #5 was reviewed on 3/24/14 at 10:55 a.m. The resident's diagnoses included, but were not limited to, anxiety, end stage dementia and Alzheimer's.</p> <p>A Physician's order dated 2/14/14, indicated the resident was to receive Haldol (an anti psychotic) 0.5 milligrams (mg) 1/2 tablet every 2 hours as needed (prn) for agitation. The resident did not have a diagnosis to support the use of the Haldol.</p> <p>Review of the February 2014 Medication Administration Record (MAR), indicated the resident received the prn Haldol on 2/23 at 7:00 p.m. and 2/28/14 at 6:00 p.m., for agitation. There was no documentation of any interventions attempted prior to giving the medication.</p> <p>Interview with the Resident Care Coordinator on 3/25/14 at 11:00 a.m.,</p>						

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