

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155715	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/02/2015
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NAME OF PROVIDER OR SUPPLIER  LUTHERAN COMMUNITY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 111 W CHURCH AVE SEYMOUR, IN 47274
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F 0000  Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey.</p> <p>Survey dates: October 26, 27, 28, 29, 30, and November 2, 2015</p> <p>Facility number: 000347 Provider number: 155715 AIM number: 100275440</p> <p>Census bed type: SNF/NF: 109 Residential: 35 Total: 144</p> <p>Census payor type: Medicare: 11 Medicaid: 52 Other: 46 Total: 109</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 34849 on November 6, 2015.</p>	F 0000	Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

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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F 0332 SS=D Bldg. 00	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5% was maintained, with the facility having 2 medication errors out of 28 opportunities for error, resulting in a 7.1% error rate. This affected 1 of 5 residents observed during medication administration. (Resident #36)</p> <p>Findings include:</p> <p>During an observation of medication administration on 10/29/2015 at 7:44 A.M., RN (Registered Nurse) #1 administered one tablet of Metformin HCL ER (extended release) 500 mg (milligrams) and one tablet of Potassium Chloride ER 20 mEq (milliequivalents). These two extended release tablets were crushed with Resident #36's other morning medications, mixed in applesauce and administered to the resident.</p> <p>During an interview on 10/29/2015 at 8:58 A.M., the DON indicated she could</p>	F 0332	<p>F 0332 It is the policy of this facility to ensure that it is free of medication error rates of 5% or more. Corrective Action For Resident Affected: The medication list for resident #36 was reviewed to assure all active medications were appropriate to be crushed. The physician was contacted for any medications that were not appropriate and the medications were changed to a crushable form. Other Residents Having The Potential To Be Affected: All residents that take their medications in crushed form have the potential to be affected. A list was gathered of all residents in the facility for which the nurses crush medications. From this list, each resident's medication list was reviewed to assure all active medications were appropriate to be crushed (Attachment titled Medication Review for Appropriate Medication Crushing). The physician was contacted for any medications that were not appropriate and the medications were changed to a crushable form. Systemic Changes and Steps To Assure Deficient</p>	11/17/2015

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	<p>not find an active order to crush the indicated medications for Resident #36.</p> <p>During an interview on 10/29/2015 at 9:32 A.M., RN #1 indicated she had crushed the resident's extended release medication and both medications were on the "Do Not Crush" list. RN #1 further indicated she should have checked the list, which was kept at the front of the narcotics book, before crushing them.</p> <p>The clinical record for Resident #36 was reviewed on 10/29/2015 at 8:45 A.M. The current physician orders for Resident #36 indicated Metformin HCL ER (Glucophage XR) 500 mg, take one tablet by mouth daily and Potassium Chloride (K-dur/Klor-con M20) tablet ER 20 mEq, take one tablet by mouth daily. Resident #36's clinical record did not contain an order for the Metformin and Potassium medications to be crushed.</p> <p>The current pharmacy guidelines titled, "Oral Dosage Forms That Should Not Be Crushed" and dated 10/1/2011, was provided by the Administrator on 10/29/2015 at 9:41 A.M. and reviewed at that time. The guidelines indicated Klor-con (potassium) slow-release tablets and Glucophage XR (metformin) slow-release tablets should not be crushed.</p>		<p>Practice Does Not Recur: Nursing staff will notify the Director of Nursing whenever a resident changes from taking medications whole to taking them in crushed form and/or a newly admitted resident receives their medication in crushed form. The Director of Nursing or designee will then print the resident's medication list and review it to assure all active medications are appropriate to be crushed. The physician will be contacted for any medications that are not appropriate and the medications will be changed to a crushable form. The pharmacy has provided pamphlets titled "Medications Not To Be Crushed." These will be available for reference at each medication cart in the facility. When new orders are received for a resident for which the nurses crush medications, the nurse will use the pamphlet titled "Medications Not To Be Crushed" as a reference to assure the new medication is appropriate for crushing. If it is not, the nurse will contact the physician for necessary changes to the medication. Education will be completed for nurses to review the "Medications Not To Be Crushed" pamphlet (Attachment titled Nurse Education for Plan of Correction) and the need to notify the Director of Nursing whenever a resident changes from taking medications whole to taking them</p>				

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R 0000 Bldg. 00	<p>3.1-25(b)(9) 3.1-48(c)(1)</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Residential Census: 35 Sample: 9</p> <p>This State finding is cited in accordance with 410 IAC 16.2-5.</p>	R 0000	<p>in a crushed form and/or a newly admitted resident receives their medications in crushed form. The Director of Nursing or designee will keep an audit tool for tracking of residents reviewed (Attachment titled Medication Review For Appropriate Medication Crushing). Monitoring For Corrective Action: Audit results will be reviewed by the Quality Assurance Performance Improvement Committee monthly for six months.</p> <p>Submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.</p>		
R 0295 Bldg. 00	<p>410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure medications kept in resident rooms for</p>	R 0295	<p>R 0295 It is the policy of this facility that residents who self-medicate may keep and use prescription medications in their</p>	11/17/2015	

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	<p>self-administration were stored appropriately in locked compartments for 3 of 3 residents reviewed for self-administration of medications. (Residents #7, #8 and #9)</p> <p>Findings include:</p> <p>During an interview on 11/02/2015 at 10:06 A.M., the Nurse Manager indicated residents could keep controlled substances in their rooms and self administer them if their evaluation had indicated they were able to do so. She further indicated no lockable drawer or cabinet was provided by the facility in the residents' rooms and that Resident #7 kept her Percocet pain medicine in her room.</p> <p>During an observation and interview with Resident #7 and RN (Registered Nurse) #5 on 11/02/2015 at 10:13 A.M., the resident walked down the hall, into her unlocked room and opened a cabinet revealing her medication bottles. Percocet 5-325 mg (milligrams), Bupropion XL 150 mg and Cymbalta 30 mg were noted in the unlocked cabinet.</p>		<p>unit/apartment as long as they keep them secured from other residents. Corrective Action For Residents Affected: Residents #7, 8, and 9 were educated that they were required to keep the doors to their apartments locked when they leave their apartment and that medications should be secured and not left out on the countertop in easy view of others who enter the room. Other Residents Having The Potential To Be Affected: All residents who self-medicate have the potential to be affected. A list was gathered of all residents who self-medicate. From this list, each resident was educated that they are required to lock the door to their apartment when they leave their apartment and to keep their medications secured and not left out on the countertop in easy view of others who enter the room. (Attachment Titled Education For Residents Who Self-Medicate). Systemic Changes And Steps To Assure Deficient Practice Does Not Recur: The Pharmaceutical Services Policy was updated with additional language regarding residents who self-medicate. The following statement was added: Residents who self-medicate are responsible to keep the door to their apartment locked when they leave the apartment and are required to keep their medications secured and out of the view of others who enter their</p>		

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	<p>Resident #7 indicated her daughter helps her set up her medicine and she had a weekly medicine organizer filled with pills.</p> <p>During an observation on 11/02/2015 at 10:20 A.M., Resident #8 had medications in an unlocked cabinet in her bathroom that included Diazepam 5 mg, Enalapril 5 mg and Simvastatin 40 mg. The door to the resident's room was unlocked.</p> <p>During an observation on 11/02/2015 at 10:25 A.M., Resident #9 had medications in an unlocked cabinet in the bathroom that included, but were not limited to, Lasix 40 mg, Clonidine 0.1 mg, Synthroid 50 mcg, Lorazepam 0.5 mg, Sertraline 25 mg, and Clopidogrel 75 mg. The resident also had a weekly medicine organizer on the counter in the kitchen area filled with pills. The door to the resident's room was unlocked.</p> <p>During an interview on 11/02/2015 at 10:42 A.M., Resident #9 indicated she never locks her door when she goes to activities or meals.</p>		<p>room. (Attachment titled Pharmaceutical Services Policy). The nursing staff members were educated on the change to this policy and practice (Attachment titled Nursing Education Regarding Pharmaceutical Services Policy and Door Lock Audit). The nurse manager and/or nursing staff will check the doors of the residents who self-medicate to ensure that the residents are following this policy. (Attachment titled Door Lock Audit). The nurse or nurse manager will check for locked apartment doors and secured medications for all self-medicating residents once daily while they are out of their apartments for 30 business days, then three times weekly for four weeks, and then once per week for four weeks. (Attachment titled Guidelines For Door Lock Audit). Monitoring of Corrective Action: Audit results will be reviewed by the Quality Assurance Performance Improvement Committee monthly for six months.</p>	

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	<p>During an interview on 11/02/2015 at 10:44 A.M., Resident #8 indicated she never leaves her purse in her room when leaving for activities and meals because she never locks her door when leaving the room.</p> <p>The Pharmaceutical Services Policy with a revision date of 01/01, was provided by the Nurse Manager on 11/02/2015 at 10:32 A.M. and identified as current. The policy indicated, but was not limited to the following, "...1. Residents who self medicate may keep and use prescription and non-prescription medications in their unit as long as they keep them secured from other residents..."</p>			