

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00181512.</p> <p>Complaint: IN00181512 - Substantiated. Federal/State deficiency related to the allegation is cited at F431.</p> <p>Survey dates: October 8 &amp; 9, 2015</p> <p>Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190</p> <p>Census Bed Type: SNF/NF: 80 Total: 80</p> <p>Census Payor Type: Medicare: 4 Medicaid: 65 Other: 11 Total: 80</p> <p>Sample: 3 Supplemental sample: 11</p> <p>This deficiency reflects state finding cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on</p>	F 0000		

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 0431 SS=E Bldg. 00	<p>October 16, 2015.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>			

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	<p>Based on observation, record review and interview the facility failed to ensure a system that reviewed periodic usage, disposition and reconciliation/accounting of controlled medications/narcotics for 10 of 11 supplemental sampled residents. (Residents "F", "G", "H", "I", "K", "L", "M", "N", "O", "P").</p> <p>Findings include:</p> <p>1. The record for Resident "F" was reviewed on 10-09-15 at 9:45 a.m. The resident had a physician order dated 10-02-15, for Oxycodone/Acetaminophen (a pain medication) 7.5/325 mg (milligrams) one by mouth every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m.</p> <p>A review of the "Controlled Narcotic Record," on 10-08-15 at 1:10 p.m., with Licensed Nurse #8 in attendance, the resident's narcotic sheet, as well as the MAR (Medication Administration Record) was reviewed.</p> <p>The narcotic sheet indicated the prescribed medication was given at 10:30 a.m., and 9:00 p.m., on 10-03-15, 3:30 a.m., on 10-05-15 and then again on 10-05-15 at 6:00 a.m. The record lacked documentation the medication was dispensed at 12:00 a.m., on 10-07-15 or</p>	F 0431	<p>Harcourt Terrace respectfully requests a desk review because all alleged deficient practices have been corrected and the facility is in compliance. This plan of correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this plan is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice? Medication Administration Records and Narcotic Logs for all residents on scheduled narcotics were reviewed and any residents found to be affected by the alleged deficient practice were assessed for adverse effects of alleged deficient practice and will continue to be monitored. MD, POA, Family and resident notified of alleged deficient practice per policy. Any occurrence of alleged deficient practice was addressed by DNS/Designee per policy. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who have orders for scheduled narcotics have the potential to be affected. DNS/Designee will audit Medication Administration Record</p>	10/29/2015

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	<p>on 10-08-15.</p> <p>A review of the MAR (Medication Administration Record) indicated the medication was initialed by the Licensed Nurse, as dispensed at 12:00 a.m., on 10-07-15 and 10-08-15.</p> <p>The resident also had physician orders dated 10-01-15 for Lyrica (a pain medication) 50 mg one capsule by mouth three times daily at 9:00 a.m., 1:00 p.m., and 9:00 p.m.</p> <p>A review of the narcotic sheet for this prescribed medication, indicated the resident did not receive the medication on 09-23-15 at 1:00 p.m., or 9:00 p.m. In addition the record indicated the resident did not receive the medication on 09-24-15 at 9:00 a.m., or 1:00 p.m., 10-03-15 at 1:00 p.m., and 10-04-15 at 1:00 p.m. The document indicated the resident received the medication at 5:00 p.m., on 10-05-15, not the scheduled time.</p> <p>A review of the MAR indicated the resident received the medication as initialed by the licensed nurse on 10-03-15 and 10-04-15 at 1:00 p.m. Further review of the MAR indicated the resident did receive the medication on 09-24-15 at 1:00 p.m., initialed as given.</p>		<p>for residents who received scheduled narcotic medication since October 1, 2015 to determine if MD orders were followed and recorded as ordered. MD, POA, Family and resident will be notified of any errors that are noted and progressive discipline/corrective counseling will be conducted as indicated. Any resident found to be affected by alleged deficient practice will be assessed by Licensed Nurse and MD contacted per policy. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? Licensed Nurses/QMA's reeducated on Medication Administration Procedure, accurate documentation, disposal of unused medications, medication errors and narcotic order clarification by October 29, 2015. Pharmacist will reconcile narcotics and narcotic log monthly with a nurse manager. Unit Manager/Designee will audit MAR and Narcotic Log daily for accurate medication administration and documentation and take corrective action as needed. DNS/Designee will oversee the auditing process to ensure compliance. CEC/Designee will conduct Medication Pass Procedure Skill Validation for Licensed Nurses/QMA's by October 29, 2015. Nurse</p>	

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	<p>2. The record for Resident "G" was reviewed on 10-09-15 at 9:50 a.m. The resident had physician orders for Clonazepam [an anxiety medication], dated 01-14-15 for 0.25 mg every day at 9:00 a.m.</p> <p>An additional physician order, dated 02-03-15 instructed the nursing staff to administer Clonazepam 0.5 mg every day at 4:00 p.m.</p> <p>A review of the narcotic sheet on 10-08-15 at 1:15 p.m., with Licensed Nurse #8 in attendance, indicated the resident did not receive the 0.25 dosage at 9:00 a.m., on 10-03-15, 10-04-15, 10-05-15 but instead received the 4:00 p.m., dosage of 0.5 mg. During this reconciliation, the Licensed Nurse indicated she incorrectly initialed the narcotic sheet on 10-08-15 that the resident received the 0.25 mg dosage. The nurse "lined through the entry," and documented the word "error" and initialed the document. The nurse then indicated she would have to get someone to initial with her since she gave the "wrong dosage," and then turned to the next page of the narcotic sheet for the 0.5 mg dose and documented she gave the resident the 0.5 mg at 9:00 a.m.</p>		<p>Managers will review new narcotic orders and request clarification as needed. Pharmacy will review new narcotic orders monthly to ensure clarity and request clarification as needed. How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DNS/Designee will complete the Medication Error CQI and Medication Administration Accuracy CQI weekly x 4 weeks and report the findings to the Quality Assurance Committee. Results will be reviewed in the Quality Assurance and Improvement Meeting and the CQI's will be repeated as the Quality Assurance Committee deems necessary.</p>	

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	<p>A review of the MAR indicated the licensed nurses "initialed" the medication as correctly given per dose of 0.25 mg and 0.5 mg on 10-01-15 thru 10-08-15 at 9:00 a.m., and 10-01-15 thru 10-07-15 at 4:00 p.m.</p> <p>3. The record for Resident "H" was reviewed on 10-09-15 at 9:55 a.m. The resident had physician orders dated 05-05-15 for Lyrica 50 mg two times a day scheduled at 9:00 a.m., and 5:00 p.m.</p> <p>A review of the Controlled narcotic record indicated the resident did not received the 5:00 p.m., dosage on 10-04-15. However a review of the MAR indicated the resident did receive the medication as ordered per the "initials" documented on the medication record.</p> <p>In addition the Controlled narcotic record lacked documentation the resident received the medication on 10-02-15 at 9:00 a.m., and on 10-04-15 at 5:00 p.m.</p> <p>4. The record for Resident "I" was reviewed on 10-09-15 at 10:00 a.m. The resident had physician orders dated 05-12-15 for Tramadol (a pain medication) 50 mg - two tablets four times a day for back pain. The times the medication was scheduled included 9:00</p>			

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	<p>a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>A review of the narcotic sheet indicated the medication was administered at 8:00 p.m., and again at 9:00 p.m., on 09-26-15. In addition the record indicated the resident did not receive the medication on 10-03-15 at 5:00 p.m.</p> <p>However a review of the MAR indicated the resident received the medication as ordered per the initials of the licensed nurse on the administration record.</p> <p>5. The record for Resident "K" was reviewed on 10-09-15 at 10:05 a.m. The resident had physician orders dated 09-03-15 for Norco (a pain medication) 10-325 mg for wound pain every four hours.</p> <p>The record indicated the scheduled times included 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., 10:00 p.m., and 6:00 a.m.</p> <p>A review of the narcotic record indicated the resident did not receive the medication as prescribed on 09-29-15 at 2:00 p.m., 10-02-15 at 2:00 p.m., and 10-07-15 at 2:00 p.m.</p> <p>However a review of the MAR indicated the medication had been given as</p>			

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	<p>initialed by the licensed nurse.</p> <p>6. The record for Resident "L" was reviewed on 10-09-15 at 10:10 a.m. The resident had physician orders dated 08-15-15 for Ativan (an antianxiety medication) 0.5 mg three times a day for anxiety. The scheduled times included 9:00 a.m., 1:00 p.m., and 5:00 p.m.</p> <p>The resident had an additional order dated 07-31-15 for Tramadol 50 mg - give 25 mg four times a day. The scheduled times included 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>A review of the narcotic sheet on 10-08-15 at 1:00 p.m., with Licensed Nurse #6 in attendance, indicated the resident did not receive either medication on 10-08-15 at 9:00 a.m.</p> <p>During interview on 10-08-15 at 1:00 p.m., Licensed Nurse #6 indicated "I gave both medications at 9:00 a.m., and signed them off on the MAR but not on the narcotic record."</p> <p>7. The record for Resident "M" was reviewed on 10-09-15 at 10:15 a.m. The resident had physician orders dated 09-22-15 for Oxycodone (a pain medication) 20 mg two tablets every four hours for severe pain. The scheduled</p>			

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	<p>times for medication administration included 2:00 a.m., 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., 10:00 p.m., and 6:00 a.m.</p> <p>A review of the narcotic sheet indicated the resident did not receive the medication on 10-07-15 at 10:00 p.m., and did not receive the scheduled dose on 10-08-15 at 10:00 a.m.</p> <p>During interview on 10-08-15 at 1:00 p.m., Licensed Nurse #6 indicated "I gave the medication today (10-08-15) at 10:00 a.m., but didn't sign it off on the narcotic sheet only on the MAR."</p> <p>8. The record for Resident "N" was reviewed on 10-09-15 at 10:20 a.m. The resident had physician orders dated 09-11-15 for Alprazolam (an antianxiety medication) for 0.25 mg one tablet twice daily.</p> <p>The scheduled times included 9:00 a.m., and 9:00 p.m. A review of the narcotic administration record indicated the resident did not receive the 9:00 a.m., dosage on 10-08-15.</p> <p>During the reconciliation of the narcotic sheet on 10-08-15 at 1:00 p.m., Licensed Nurse #6 indicated "I gave the medication today (10-08-15) at 10:00</p>			

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	<p>a.m., but didn't sign it off on the narcotic sheet only on the MAR."</p> <p>9. The record for Resident "O" was reviewed on 10-09-15 at 10:25 a.m. The resident had physician orders dated 04-07-15 for Hydrocodone/Acetaminophen 5-325 mg once daily prior to wound care at 9:00 a.m., and an additional physician order dated 12-12-14 for Tramadol 50 mg three times a day. The scheduled times included 9:00 a.m., 1:00 p.m., and 9:00 p.m.</p> <p>A review of the narcotic sheet on 10-08-15 at 1:00 p.m., with Licensed Nurse #8 in attendance, indicated the resident did not receive the Hydrocodone/Acetaminophen medication on 09-18-15 thru 09-21-15, 10-01-15 or 10-04-15. The narcotic sheet indicated the resident did not receive the Tramadol 50 mg on 10-05-15 at 9:00 p.m.</p> <p>The Licensed Nurse indicated she did not give the dose on 10-08-15 at 9:00 a.m. "I wasted it. I will need to get someone to sign this narcotic sheet with me."</p> <p>Although the record indicated "wasted" there was no other signature to validate the destruction of the medication.</p>			

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	<p>Further review of the narcotic record indicated the resident did not receive the scheduled doses on 10-06-15.</p> <p>A review of the MAR indicated the medications were initialed as administered.</p> <p>10. The record for Resident "P" was reviewed on 10-09-15 at 10:30 a.m. The resident had physician orders for Ultram (a pain medication) 50 mg three times a day. The scheduled times included 9:00 a.m., 1:00 p.m., and 5:00 p.m.</p> <p>A review of the controlled narcotic sheet on 10-08-15 at 2:00 p.m., with Licensed Nurse #5 in attendance, she indicated the resident incorrectly received the medication on 10-07-15 at 9:00 a.m., 1:00 p.m., 5:00 p.m., and 6:00 p.m.</p> <p>During an interview on 10-08-15 at 2:30 p.m., the Director of Nurses was alerted to the accuracy's of the narcotic records versus the documentation on the Medication Administration Records and controlled drugs being wasted without being verified. The Director of Nurses indicated "This is basic nursing."</p> <p>A review of the facility policy on 10-09-15 at 12:00 p.m., titled, "Medication Pass Procedure - Skills</p>			

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	<p>Validation," and dated 03-2013, indicated the following:</p> <p>"Procedure Steps": ... 8. Refusal of medication - identified by circling the initial and document on back of MAR (Medication Administration Record. ... 17. Medication administration will be recorded on the MAR or TAR after given.</p> <p>18. Wasted or dropped medication destroyed and documented per policy."</p> <p>A review of the facility policy on 10-09-15 at 12:00 p.m., titled, "Disposal of unused medication," and dated 01-03-2013, indicated the following:</p> <p>"Purpose" To provide American Senior Communities some disposal options and some special disposal instructions to consider when throwing out expired, unwanted, or unused medicines.</p> <p>"Frequency" Each time a medication supply is no longer needed for any reason."</p> <p>"Acceptable medication destruction practice's: Who can dispose of medications - Controlled substances and any other medication that is maintained under a double lock system must be destroyed by no less than two (2) licensed</p>			

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	<p>nurses and one (1) of the licensed nurses must hold a current registered nursing licensed recognized by the state of Indiana."</p> <p>A review of the contracted service policies from the Pharmacy on 10-09-15 at 10:00 a.m., included the following:</p> <p>"Med Pass General Guidelines - Policy # 2.04.01 Purpose: To ensure compliance of the five residents rights with Federal and State Rules. Regulations and Guidelines and to maintain safe administration of sanitary dispensing practices. 1. Right resident, 2. Right medication, 3. Right time, 4. Right dosage, and 5. Right route. ... 3.0 The Nurse should check the medications(s) three (3) times with the Medication Administration Record (MAR) in order to verify the order with the label. ... 10. It is recommended that medication be charted immediately after administration, but if facility policy permits, medication may be charted immediately before administration. Initials are to be used: check marks are not acceptable. 10.1 Refusal of medication(s) should be identified by circling initials and documenting on the back of the MAR. 11.0 Controlled substances should be logged out in the narcotic log with each use.... 14.0 Medication errors and drug</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155149	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2015
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NAME OF PROVIDER OR SUPPLIER  HARCOURT TERRACE NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 8181 HARCOURT RD INDIANAPOLIS, IN 46260
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	<p>reactions must be immediately reported to the resident's physician, the DON [Director of Nurses], the administrator, and the resident's responsible party. An entry must be made in the resident's clinical record and an incident report as per the facility and procedure, completed."</p> <p>"Medication Administration - Policy # 2.04.02 Med [medication] - pass Oral medication. Purpose: The purpose of this policy is to establish guidelines for correctly administering oral medications according to the manufacturers' recommendations and the physician's orders. Procedure # 8.0 - The nurse is to document the medication(s) administration on MAR, including other pertinent information."</p> <p>"Medication Monitoring - Purpose: To establish a system for reporting medication errors, including medication administration errors. Procedure: 1. If a medication error or medication administration error is discovered, a facility incident report is to be completed and signed by the appropriate personnel. ... The prescriber, consultant pharmacist and resident and in some instances either the POA [Power of attorney], or responsible party will be notified of any errors immediately."</p>			

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	<p>This Federal tag relates to Complaint IN00181512.</p> <p>3.1-25(b)(3) 3.1-25(e)(2) 3.1-25(o)</p>			