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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 01/14/2016 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE | STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374 |
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| F 0000 Bldg. 00 | <p>This visit was for the Investigation of Complaint IN00189040.</p> <p>Complaint IN00189040-Substantiated. Federal/State deficiencies related to the allegations are cited at F176 and F425.</p> <p>Survey dates: January 13 and 14, 2016</p> <p>Facility number: 000165 Provider number: 155264 AIM number: 100288220</p> <p>Census bed type: SNF/NF: 112 Total: 112</p> <p>Census payor type: Medicare: 17 Medicaid: 77 Other: 18 Total: 112</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on January 20, 2016.</p> | F 0000 | Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable State and Federal regulatory requirements. | |
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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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| F 0176 SS=D Bldg. 00 | <p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>Based on observation, interview and record review, the facility failed to ensure nursing staff observe a resident consume prescribed medication prepared by the nursing staff for 1 of 3 residents reviewed for medications in a sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>During 1 of 2 Medication Pass Observations with 1 of 2 LPN's on 1-13-16, LPN #1 was observed to prepare the prescribed medications for Resident #C at 7:08 p.m. and then to enter the resident's room and set the medication cup on the overbed table and hand her the liquid medication. She was observed to speak to the resident during this time and then exit the room prior to observing the resident consume the medications. LPN #1 went out into the hall to the</p> | F 0176 | <p>F176</p> <p>The corrective actions accomplished for those residents found to have been affected by the deficient practice are as follows: Immediately LPN was in-serviced by Director of Clinical Education on proper medication pass with 1:1 demonstration. She also received a written discipline per facility protocol. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Director of Clinical Education immediately in-serviced all licensed nursing staff on proper medication administration. The measures put into place and the systemic changes made to ensure that this deficient practice does not</p> | 01/18/2016 |

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| | <p>medication cart and begin to prepare medications for another resident and deliver the medications to the other resident. Upon completion of the medication pass with the other resident at 7:25 p.m., an observation was conducted with Resident #C in which she indicated she had consumed all the medications with no medications observed on her overbed table.</p> <p>In an interview with LPN #1 on 1-13-16 at 7:27 p.m., she indicated "I try to give her some freedom to take her medicine like she did at home. Try not to hover. She's very alert and oriented. She's always one that counts her pills to make sure everything is there and is real quick to let you know if there is a problem. This is her home and I try to honor that. We have several people that can self-medicate with the doctor's okay. I always go back and check to see if her medicine is gone." At 7:30 p.m., LPN #1 was observed to enter Resident #C's room and speak with the resident. Upon exiting the room, LPN #1 indicated, "I saw her pill cup was in the trash."</p> <p>The medications prepared by LPN #1 for Resident #C on 1-13-16 at 7:08 p.m., were the following medications: -Aricept 10 mg po (orally) at each bedtime.</p> | | | | <p>recur are as follows: Nurse Management will be doing random rounds on LPN withdeficient practice and random rounds on other license personnel to ensure she and other nurses are compliant with their medication administration. Medication Audit rounds will be made on each shift for 7 (seven) days, then on random shifts five times per week for 4 (four) week, then once a week on different shifts for 60 days. Results of the audit will be brought to the following QAPI meeting. LPN with deficient practice has been transferred to a unit where she will have RN spvr. working with her. These corrective actions will be monitored and a quality assurance program implemented to ensure thedeficient practice will not recur per the following: Directorof Clinical Education immediately in-serviced all licensed nursing staff on propermedication administration. Nurse Management will bedoing random rounds on LPN with deficient practice and random other licensepersonnel to ensure she is compliant with her medication administration. ED/DNS/Designee will reportfindings of audits to</p> | | |

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| | <p>-pramipexole 0.125 mg po at each bedtime.</p> <p>-atoravastatin 10 mg po at each bedtime.</p> <p>-duloxetine 30 mg po at each bedtime.</p> <p>-atenolol 25 mg po at each morning and at each bedtime.</p> <p>-Ferrex 150 mg po twice daily.</p> <p>-Seroquel XR 400 mg po at each bedtime.</p> <p>-amitriptyline 25 mg, one-half tablet, po at each bedtime.</p> <p>-Calcium 600 mg po at each morning and at each bedtime.</p> <p>-Requip 1 mg po at each bedtime.</p> <p>-Miralax Powder 17 grams po in 4 ounces of water twice daily.</p> <p>-clonazepam 0.5 mg po at each bedtime.</p> <p>In an interview with Resident #C on 1-14-16 at 10:15 a.m., she indicated some nurses remain with her to observe her take her medications and some nurses leave medications with her without observing her consume the medications.</p> <p>On 1-14-16 at 11:00 a.m., Resident #C's clinical record was reviewed. It indicated her diagnoses included, but were not limited to, diabetes, anxiety, depression, bipolar disorder, dementia with behavioral disturbances, atrial fibrillation and hypertension. Her most recent Minimum Data Set assessment, dated 12-25-15, indicated she is cognitively</p> | | <p>monthly QAPI meetings for 6 months, any patterns ortrends will have an action plan written and interventions implemented.</p> | |

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| | <p>intact. An assessment for medication self administration was not located. An order from Resident #C's physician for medication self administration was not located. A care plan for medication self administration was not located.</p> <p>On 1-14-16 at 3:50 p.m., the DON provided a copy of a document entitled, "3 Step Employee Memorandum," dated 1-14-16. It indicated on 1-13-16 she had been observed to leave a cup of medications in Resident #C's room, "left it there without watching the resident take their medications. This is against policy and is not acceptable practice. You have been counseled in the past for leaving medications at the bedside...Never leave medications at bedside for any patient. Patients are able to have medications at bedside if they have a physician's order and a self-administration assessment completed and care planned in their chart. You are to visually ensure they have taken their medications before leaving the room and then documenting in MAR..."</p> <p>On 1-14-16 at 3:40 p.m., the DON provided documentation in which LPN #1 had successfully completed an annual nursing competency, dated 6-4-15, related to the topic of "Medication Administration."</p> | | | |

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| | <p>On 1-14-16 at 1:45 p.m. the DON provided a copy of a policy entitled, "Medication Administration-General Guidelines." This policy had a revision date of November, 2011, and was indicated to be the current policy utilized by the facility. This policy indicated, "...The person who prepares the dose for administration is the person who administers the dose...Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications...The resident is always observed after administration to ensure that the dose was completely ingested...The individual who administers the medication dose records the administration on the resident's MAR [medication administration record] directly after the medication is given..."</p> <p>On 1-14-16 at 1:45 p.m. the DON provided a copy of a policy entitled, "Self Administration of Medications." This policy had a revision date of November, 2011, and was indicated to be the current policy utilized by the facility. This policy indicated, "In order to maintain the resident's high level of independence, resident's who desire to self-administer medications are permitted to do so if the</p> | | | |

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| F 0425 SS=D Bldg. 00 | <p>facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer."</p> <p>This Federal tag relates to Complaint IN00189040.</p> <p>3.1-11(a)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure nursing staff did not leave medications at</p> | F 0425 | F425 The corrective actions accomplished for those | 01/18/2016 |

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| | <p>the bedside of a resident and failed to supervise the resident consume the medication for 2 of 3 residents reviewed for medications in a sample of 3. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. During 1 of 2 Medication Pass Observations with 1 of 2 LPN's on 1-13-16, LPN #1 was observed to prepare the prescribed medications for Resident #C at 7:08 p.m. and then to enter the resident's room and set the medication cup on the overbed table and hand her the liquid medication. She was observed to speak to the resident during this time and then exit the room prior to observing the resident consume the medications. LPN #1 went out into the hall to the medication cart and begin to prepare medications for another resident and deliver the medications to the other resident. Upon completion of the medication pass with the other resident at 7:25 p.m., an observation was conducted with Resident #C in which she indicated she had consumed all the medications with no medications observed on her overbed table.</p> <p>In an interview with LPN #1 on 1-13-16 at 7:27 p.m., she indicated "I try to give her some freedom to take her medicine</p> | | <p>residents found to have been affected by the deficient practice are as follows: Immediately LPN was in-serviced by Director of Clinical Education on proper medication pass with 1:1 demonstration. She also received a written discipline per facility protocol. Other residents having the potential to be affected by the same deficient practice will be identified and the corrective actions taken are as follows: Director of Clinical Education immediately in-serviced all licensed nursing staff on proper medication administration. The measures put into place and the systemic changes made to ensure that this deficient practice does not recur are as follows: Nurse Management will be doing random rounds on LPN with deficient practice and random rounds on other license personnel to ensure she and other nurses are compliant with their medication administration. Medication Audit Rounds will be done on every shift for 7 days, then 5 times weekly on various shifts for 4 weeks, then weekly on different shifts for 60 days, audit results will be reviewed at the following QAPI meeting LPN with deficient practice has</p> | | | | |

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| | <p>like she did at home. Try not to hover. She's very alert and oriented. She's always one that counts her pills to make sure everything is there and is real quick to let you know if there is a problem. This is her home and I try to honor that. We have several people that can self-medicate with the doctor's okay. I always go back and check to see if her medicine is gone." At 7:30 p.m., LPN #1 was observed to enter Resident #C's room and speak with the resident. Upon exiting the room, LPN #1 indicated, "I saw her pill cup was in the trash."</p> <p>The medications prepared by LPN #1 for Resident #C on 1-13-16 at 7:08 p.m., were the following medications: -Aricept 10 mg po (orally) at each bedtime. -pramipexole 0.125 mg po at each bedtime. -atorvastatin 10 mg po at each bedtime. -duloxetine 30 mg po at each bedtime. -atenolol 25 mg po at each morning and at each bedtime. -Ferrex 150 mg po twice daily. -Seroquel XR 400 mg po at each bedtime. -amitriptyline 25 mg, one-half tablet, po at each bedtime. -Calcium 600 mg po at each morning and at each bedtime. -Requip 1 mg po at each bedtime.</p> | | <p>beentransferred to a unit where she will have RN spvr. working with her. These corrective actions will be monitored and a quality assurance program implemented to ensure the deficient practice will not recur per the following: Director of Clinical Education immediately in-serviced all licensed nursing staff on proper medication administration. Nurse Management will be doing random rounds on LPN with deficient practice and random other license personnel to ensure she is compliant with her medication administration. ED/DNS/Designee will report findings of audits to monthly QAPI meetings for 6 months, any patterns or trends will have an action plan written and interventions implemented.</p> | | |

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| | <p>-Miralax Powder 17 grams po in 4 ounces of water twice daily. -clonazepam 0.5 mg po at each bedtime.</p> <p>In an interview with Resident #C on 1-14-16 at 10:15 a.m., she indicated some nurses remain with her to observe her take her medications and some nurses leave medications with her without observing her consume the medications.</p> <p>On 1-14-16 at 11:00 a.m., Resident #C's clinical record was reviewed. It indicated her diagnoses included, but were not limited to, diabetes, anxiety, depression, bipolar disorder, dementia with behavioral disturbances, atrial fibrillation and hypertension. Her most recent Minimum Data Set assessment, dated 12-25-15, indicated she is cognitively intact. An assessment for medication self administration was not located. An order from Resident #C's physician for medication self administration was not located. A care plan for medication self administration was not located.</p> <p>On 1-14-16 at 3:50 p.m., the DON provided a copy of a document entitled, "3 Step Employee Memorandum," dated 1-14-16. It indicated on 1-13-16 she had been observed to leave a cup of medications in Resident #C's room, "left it there without watching the resident</p> | | | |

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| | <p>take their medications. This is against policy and is not acceptable practice. You have been counseled in the past for leaving medications at the bedside...Never leave medications at bedside for any patient. Patients are able to have medications at bedside if they have a physician's order and a self-administration assessment completed and care planned in their chart. You are to visually ensure they have taken their medications before leaving the room and then documenting in MAR..."</p> <p>2. In an interview with a family member of Resident #B on 1-14-16 at 9:27 a.m., she indicated she had experienced LPN #1 leave medications in Resident #B's room previously. She indicated, "The one time, my sisters and I were there, between 7:00 p.m., and 7:30 p.m., and Dad seemed to have no idea it '[the medications] was there...on his overbed table...concerns me that someone could pick those pills up...he really needs his medicines." She indicated this occurred in mid-December, 2015.</p> <p>On 1-14-16 at 3:40 p.m., the Director of Nursing (DON) provided a copy of an "Informal Counseling," dated 12-15-16, related to LPN #1 and Resident #B. This document indicated, "Resident's daughter reports that she entered her father's room</p> | | | |

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| | <p>and found a cup of medications sitting there...[name of LPN #1] was the nurse working that shift...Spoke with [name of LPN #1] and she stated no [sic] she does not leave his medications sitting at bedside and she does watch to ensure he takes his medications. [Name of LPN #1] stated that she may have been called away on an emergency and forgot [sic] that would be the only way she would have left any medication and it would not be on purpose. Explained to [name of LPN #1] that she was never to leave medications at bedside for a patient unless that [resident] had an MD [medical doctor/physician's] order along with a self administration assessment in the chart. She acknowledged understanding."</p> <p>Resident #B's clinical record was reviewed on 1-13-16 at 5:10 p.m. It indicated his diagnoses included, but was not limited to, hypertension, chronic venous hypertension, ocular hypertension, diabetes, morbid obesity, chronic pain and mild cognitive impairment. His most recent Minimum Data Set assessment, dated 12-7-15, indicated he had severe cognitive impairment.</p> <p>On 1-14-16 at 3:40 p.m., the DON provided documentation in which LPN</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-GOLDEN RULE | STREET ADDRESS, CITY, STATE, ZIP CODE 2330 STRAIGHT LINE PIKE RICHMOND, IN 47374 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
| | <p>#1 had successfully completed an annual nursing competency, dated 6-4-15, related to the topic of "Medication Administration."</p> <p>On 1-14-16 at 1:45 p.m. the DON provided a copy of a policy entitled, "Medication Administration-General Guidelines." This policy had a revision date of November, 2011, and was indicated to be the current policy utilized by the facility. This policy indicated, "...The person who prepares the dose for administration is the person who administers the dose...Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications...The resident is always observed after administration to ensure that the dose was completely ingested...The individual who administers the medication dose records the administration on the resident's MAR [medication administration record] directly after the medication is given..."</p> <p>On 1-14-16 at 1:45 p.m. the DON provided a copy of a policy entitled, "Self Administration of Medications." This policy had a revision date of November, 2011, and was indicated to be the current policy utilized by the facility. This policy</p> | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155264 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 01/14/2016 |
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| | <p>indicated, "In order to maintain the resident's high level of independence, resident's who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer."</p> <p>This Federal tag relates to Complaint IN00189040.</p> <p>3.1-25(b)(1) 3.1-25(b)(3) 3.1-25(b)(4)</p> | | | |