

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155095	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/15/2015
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NAME OF PROVIDER OR SUPPLIER  HERITAGE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN 46805
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit included the Investigation of Complaint IN00160879.</p> <p>Complaint IN00160879 - Unsubstantiated.</p> <p>Survey Dates: January 8, 9, 12,13, 14, 15, 2015</p> <p>Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830</p> <p>Survey Team: Martha Saull, RN TC Julie Call, RN Sue Brooker, RD Virginia Terveer, RN Angela Strauss, RN 1/8, 1/9, 1/12, 1/13/2015</p> <p>Census Bed Type: SNF: 19 SNF/NF: 144 Residential: 24 Total: 187</p> <p>Census Payor Type: Medicare: 21</p>	F000000	Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review on or after February 14, 2015.	

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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F000332 SS=D	<p>Medicaid: 107 Other: 59 Total: 187</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 16, 2015 by Randy Fry RN.</p> <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 it was free of a medication error rate greater than 5% with the facility having 2 medication errors out of 25 opportunities for error, resulting in an 8% error rate. This affected 2 of 13 residents observed for medication pass (Resident # 179, Resident #247) and 2 of 6 nurses observed to pass medications (LPN #4, LPN # 5).</p> <p>Findings include:</p> <p>On 1/12/15 at 11:42 a.m. LPN #4 was observed to administer 12 units of Novolog Insulin (rapid acting medication</p>	F000332	F332It is the practice of this provider to ensure the facility is free of a medication error rate greater than 5%. However, based on the alleged deficient practice the following has been implemented:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #179Resident receives his rapid onset insulin prior to the meal in conjunction with a 4oz glass of juice to reduce the risk of hypoglycemia pending delivery of his meal. Resident # 247Resident receives her rapid onset insulin prior to the meal in conjunction with a 4oz glass of juice to reduce the risk of hypoglycemia pending delivery of her meal. How will you identify	02/10/2015

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	<p>to control blood sugar) to Resident #179. At the time, LPN #4 was interviewed. She indicated the resident would eat in "about 10 minutes." Resident #179 was observed to actually get his meal at 12:10 p.m.</p> <p>On 1/14/15 at 11:00 a.m. Resident #247 was observed to have her blood sugar checked with a result of 102. At 11:05 a.m. LPN # 5 was observed to administer 20 units of Novolog insulin to Resident #247. The noon meal arrived in the north dining room at 11:41 a.m. The resident remained in her room at this time.</p> <p>On 1/14/15 at 11:17 a.m. the LPN #5 was interviewed. She indicated residents in the dining room would begin eating between 11:45 a.m. - 12 p.m.</p> <p>On 1/14/15 at 11:45 a.m. Resident #247 was interviewed in her room. She indicated she eats in the north dining room and would be down to the dining room in about 5 or 10 minutes.</p> <p>On 1/14/15 at 11:52 a.m. Resident #247 was observed to walk to the north unit dining room. At 11:55 a.m. LPN #5 served the resident some juice. The resident was given her meal at 11:57 a.m.</p> <p>On 1/14/15 at 11:58 a.m. LPN #5 was</p>		<p>other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:Residents living in the facility with a Dx of Diabetes requiring rapid onset insulin administration to maintain appropriate blood glucose levels have the potential to be affected by the alleged deficient practice.Residents receiving rapid onset insulin prior to meals have their insulin administered and are provided a 4oz glass of juice within 15 minutes of meal service to reduce the risk of hypoglycemia pending meal delivery. Licensed Nursing Staff have been re-educated on rapid onset insulin administration. Education includes but is not limited to types of rapid onset insulin, the need for juice after administration of the insulin, importance of meal service within 15 minutes and signs/symptoms of hypoglycemia. Education provided by DNS/Clinical Education Co-ordinator/Designee by February 10, 2015.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:Residents receiving rapid onset insulin prior to meals have their insulin administered and are provided a 4oz glass of juice within 15 minutes of meal service to reduce the risk of hypoglycemia pending meal delivery. Licensed Nursing</p>		

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	<p>interviewed. She indicated she usually tries to give Resident #247 her insulin right before the meal. When LPN #5 was made aware it had been over 50 minutes from the time the resident had been given her insulin until she was given her food, she indicated the resident had been stable and really never had any problems.</p> <p>On 1/14/15 at 1 p.m. the DON (Director of Nursing) was interviewed. She indicated the following: Novolog insulin peaks (when maximum plasma drug concentrations occurs) in 1 1/2 - 2 hours. She indicated Resident #247 had a specific order for Novolog to be given at 11 a.m. She indicated if a resident was a brittle diabetic (experienced frequent, extreme swings in blood glucose levels), the insulin should be given right before a meal. She indicated if there was no specific order for insulin administration time, the facility would try to provide the resident with the meal right after the insulin was given. The DON indicated the Novolog insulin could start acting within 10 minutes after it was given. The DON indicated after she reviewed the resident's clinical record, on 1/11/15 at 3:40 p.m. the resident had a blood sugar drop to 49 (normal 80-110), was given a protein snack with juice and the blood sugar came up to 80. The DON indicated they would use the package insert for</p>		<p>Staff have been re-educated on rapid onset insulin administration. Education includes but is not limited to types of rapid onset insulin, the need for juice after administration of the insulin, importance of meal service within 15 minutes and signs/symptoms of hypoglycemia. Education provided by DNS/Clinical Education Co-ordinator/Designee by February 10, 2015. The DNS/Designee will audit MARS daily to ensure rapid-onset insulin is administered with juice per facility procedure. The Unit Managers/Designee are responsible for compliance. How will the corrective action(s) be monitored to ensure the deficient practice will not recur: A CQI Monitoring Tool titled "Rapid Onset Insulin Administration" will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>				

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	<p>Novolog as a reference.</p> <p>On 1/14/15 at 1:21 p.m. the DON provided a copy of the package insert for Novolog, undated. The insert included, but was not limited to, the following: "WARNINGS: Novolog differs from regular human insulin by a more rapid onset and a shorter duration of activity. Because of the fast onset of action, the injection of Novolog should immediately be followed by a meal..." At the time, the DON indicated the facility did not have a policy specific to Novolog administration.</p> <p>On 1/14/15 at 2:30 p.m. the ADON (Assistant Director of Nursing) provided copies of the following: Resident #247 and Resident #179 current MARs (medication administration records), nurses notes and record of blood sugar testing results. At the time, these records were reviewed and indicated the following: Resident #247 D.O. (Doctors Order), dated 12/30/14, for "Accucheck (blood sugar check) four times a day...11 a.m.,..." D.O. for Novolog Flexpen, dated 12/30/14, indicated the following: "insulin pen 100 units/ml; amt (amount)20 units; once a day at 11 a.m." Nurses notes for Resident #247 on 1/11/15 at 10 p.m. indicated the following: "At 3:39 p.m., pt (patient ) A</p>				

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F000371 SS=E	<p>&amp; O (alert and oriented) x 3...states feels tired with BS (blood sugar) 49. Pt (patient) compliant with protein snack and juice with BS (blood sugar) recheck at 4:10 p.m. 80..." The current MAR for Resident #179 indicated the following: Accucheck two times a day at 5 a.m. and 4 p.m....Novolog 100 unit/ml, amt 12 units...TID (three times a day) 8 a.m., 11 a.m., 5 p.m..."</p> <p>3.1-25(b)(9)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure dietary staff washed hands prior to meal service after they arrived on the locked dementia unit. The facility further failed to ensure staff did not handle food with bare hands for 3 of 3 observations of meal distribution on the locked dementia unit. This had the potential to affect 26 of 26 residents who resided on the locked dementia unit.</p> <p>Findings include:</p>	F000371	F371It is the practice of this provider to ensure food is procured from sources approved or considered satisfactory by Federal, State or local authorities and food is stored, prepared, distributed and served under sanitary conditions. However, based on the alleged deficient practice the following has been implemented:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:No residents were individually identified to have	02/10/2015

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	<p>On 1/8/15 at 11:44 a.m. the lunch service was observed in the secured dementia unit. Dietary Staff #1 was observed to enter the dementia unit as he pushed a cart with covered food bins on it. After he entered the unit, he was observed to open a half door to the kitchenette area and push the food cart into the kitchen area. He then moved a cart with beverages on it from the kitchenette area to the dining area. He then reentered the kitchenette area and removed individual dining plates from the from the silverware cart without hand washing. He then pushed the cart from the kitchenette area with silverware on it and returned to the kitchenette area. He removed the plastic wrap from the food bins and put the food bins in the steam table, all without hand washing. He then removed the white binder book from the bottom of the food cart. After opening the binder, he removed the food thermometer from the protective sheath and without cleaning, and put it in the mashed potatoes. The thermometer was observed to be floating in the mashed potatoes with the dial face visible in the potatoes. Dietary Staff #1 read the thermometer and documented the temperature in the log book. He then checked the temperature of the stewed tomatoes and since he entered the unit,</p>		<p>been affected by the deficient practice. Dietary Employee #1 was immediately removed from the serving line upon facility notification of deficient practice. Disciplinary action was taken. He was provided 1:1 in-servicing/re-education on deficiencies. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents residing in the facility with oral diets have the potential to be affected by the deficient practice. Dietary staff have been re-educated on proper handwashing and appropriate handling of food. Education includes but is not limited to step by step procedure for proper handwashing, appropriate times to wash hands, when to consider yourself "contaminated" while serving food, procedure to check food temperatures including how to clean the thermometer and using appropriate tools when serving to avoid bare hand contact with the prepared food item. Education provided by the Certified Dietary Manager/Dietary Supervisor completed February 10, 2015. Certified Dietary Manager/Designee is responsible for compliance. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Dietary staff have been re-educated on</p>	

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	<p>had not washed his hands. He then used a paper towel to wipe his face and threw the paper towel away. Without hand washing, he then cleaned the thermometer probe with a cleaning wipe. He then immersed the thermometer probe into a food bin, and upon removing the thermometer probe from the food, he placed the tip of the thermometer probe in the palm of his bare hand as he read the temperature. Without cleaning the probe, he placed the thermometer probe in another food bin. After he removed the thermometer, he turned on the water in the sink behind him, ran the thermometer underneath the water stream, approximately 1 second, and then brushed the thermometer against his left side pant leg/apron. He then took the thermometer, placed it in the protective sheath and returned it to the mesh bag.</p> <p>On 1/8/15 at 12:07 p.m. Dietary Staff #1 was observed to place stewed tomatoes into bowls. As he placed the tomatoes into the bowl, a partial tomato hung over the side of the bowl, landing on Dietary Staff #1's bare hand. Dietary Staff #1 then took his hand and flipped the tomato portion into the bowl and placed the bowl on the resident's tray for service. When the food service was completed at 12:20 p.m., Dietary Staff #1 washed his hands and then wiped his brow with the bottom</p>		<p>proper handwashing and appropriate handling of food. Education includes but is not limited to step by step procedure for proper handwashing, appropriate times to wash hands, when to consider yourself "contaminated" while serving food, procedure to check food temperatures including how to clean the thermometer and using appropriate tools when serving to avoid bare hand contact with the prepared food item. Education provided by the Certified Dietary Manager/Dietary Supervisor completed February 10, 2015. The CDM/Designee will complete a "Food Service Monitoring Tool" with each meal on Augustes Cottage to ensure food is served in a safe and sanitary manner. Certified Dietary Manager/Designee is responsible for compliance. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: CQI Monitoring Tools titled "Handwashing" and "Food Service" will be utilized weekly x 4, Monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will be developed. Non-compliance with facility procedure may result in disciplinary action up to and including termination.</p>	

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	<p>outside of his apron.</p> <p>On 1/9/15 at 7:55 a.m. Dietary Staff #1 was observed on the secured dementia unit. He was observed to place the sheath of the thermometer into the pan of grits with the base of the thermometer floating in the grits. He then removed the thermometer and ran it under the water stream in the sink to rinse off the thermometer. He then checked the temperature of the scrambled eggs. Dietary Staff #1 placed the thermometer sheath in the scrambled eggs, with the base of the thermometer rested directly on the scrambled eggs. He cleaned the thermometer by running it under the water stream in the sink.</p> <p>On 1/12/15 at 11:50 a.m. the Dietary Staff #1 had pushed the cart with food bins on it behind the door to the kitchenette area of the unit. Without hand washing, he began uncovering the food bins as he placed them on the steam table. At 12:05 p.m. Dietary Staff #1 was observed to place breadsticks from the steam table on the plates with his bare hands. At the time, no tongs were observed in the kitchen area. At 12:07 p.m. Dietary Staff #2 was observed to bring in a pair of tongs in a plastic bag to the steam table. At the time, there were 5 resident trays which had breadsticks on</p>						

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	<p>them that had been served by Dietary Staff #1's bare hands.</p> <p>On 1/14/15 at 8:51 a.m. the FSM (Food Service Manager) provided the policy and procedure for Hand washing, updated November 2014. The policy included, but was not limited to, the following: "Dietary staff will wash hands after touching bare human body parts other than clean hands...or using a handkerchief or disposable tissue...after handling soiled surfaces, equipment or utensils...before touching food or food-contact surfaces...and after engaging in other activities that contaminate hands."</p> <p>On 1/14/15 at 8:51 a.m. the FSM also provided the policy and procedure for "General Food Preparation and Handling" with a revised date of April 2011. The procedure included, but was not limited to, the following: "...food will be prepared and served with clean tongs...so as to avoid bare hand contact of prepared foods...bare hands should never touch raw or ready to eat food directly..."</p> <p>On 1/15/15 at 2:30 p.m. the FSM (Food Service Manager) was interviewed. She indicated when food temperatures were obtained, the thermometer dial/base should not come in contact with the food.</p>			

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F000431 SS=E	<p>3.1-21(i)(3)</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</p>			

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	<p>quantity stored is minimal and a missing dose can be readily detected.</p> <p>A. Based on observation, interview and review of narcotic count sheets, the facility failed to ensure 4 of 7 residents with narcotics had an accurate count of their medications on the 600 hall medication cart, which was 1 of 8 medication carts reviewed in the facility. (Residents 174, 17, 90, 143)</p> <p>B. Based on observation, interview and record review, the facility failed to ensure proper labeling for Over the Counter Medications and topicals for 3 of 8 medication carts (100 and 300 hall and Auguste's Cottage) and 2 of 7 treatment carts (300 and 900 hall).</p> <p>Finding includes:</p> <p>A. On 1/13/15 at 10:50 a.m. observation of the 600 hall medication cart indicated 5 of 7 residents with narcotics did not have an accurate count of their medications. Interview with nurse #1 indicated she had counted the medications at the beginning of the shift with another nurse but had not signed the count sheet as the oncoming nurse which indicated the narcotic counts were accurate. Review of the discrepancies were as follows:</p>	F000431	F431It is the practice of this provider to ensure the services of a licensed pharmacist 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 an account of all controlled drugs is maintained and periodically reconciled. This facility also ensures drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. However, based on the alleged deficient practice the following has been implemented:What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Upon facility notification of discrepancy in narcotic count- an investigation was immediately initiated. Results of investigation revealed the nurse administering the narcotics on the 600 hall had signed out the narcotics in the electronic medical record but had failed to "sign" the individual narcotic count sheet by hand. Alert and oriented residents on 600 hall with an inaccurate count of narcotics were questioned and confirmed they had indeed	02/10/2015	

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	<p>1. Resident #174 had an order for Hydrocodone/Acetaminophen 7.5-325 milligrams. The Narcotic Count Sheet indicated the resident should have had 60 pills, but there were only 59 pills on the medication cards.</p> <p>2. Resident #17 had an order for Tramadol HCL 50 milligrams. The Narcotic Count Sheet indicated the resident should have had 113 pills but there were only 112 pills on the medication cards.</p> <p>3. Resident #90 had an order for Hydrocodone/Acetaminophen 5-325 milligrams. The Narcotic Count Sheet indicated the resident should have had 58 pills but there were only 57 pills on the medication cards.</p> <p>4. Resident #90 had an order for Tramadol 50 milligrams. The Narcotic Count Sheet indicated the resident should have had 78 pills but there were only 77 pills on the medication cards.</p> <p>5. Resident #143 had an order for Ativan 10 milligrams. The Narcotic Count Sheet indicated the resident should have had 11 pills but there were only 10 pills on the medication card.</p>		<p>received their medications as ordered. The nurse was also required to submit to a drug test performed by Parkview Occupational Health. Results of test were negative. Resident #174The administrating nurse had signed out the Hydrocodone/Acetaminophen 7.5-325mg pill in the electronic medication administration log at the time she administered the medication- but failed to hand-sign out the pill on the individual count sheet in the paper narcotic log. The count sheet was corrected.Resident #17 The administrating nurse had signed out the Tramadol HCL 50mg pill in the electronic medication administration log at the time she administered the medication- but failed to hand-sign out the pill on the individual count sheet in the paper narcotic log. The count sheet was corrected.Resident #90The administrating nurse had signed out the Hydrocodone/Acetaminophen 5-325mg pill and the Tramadol 50mg pill in the electronic medication administration log at the time she administered the medication- but failed to hand-sign out the pill on the individual count sheet in the paper narcotic log. The count sheet was corrected.Resident #143The administrating nurse had signed out the Ativan 10mg pill in the electronic medication</p>		

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	<p>On 1/13/15 at 12:15 p.m. review of the "Long Term Care Pharmacy Policy and Procedure Manual", page 63 and with a revised date of 7/2011 indicated the following:</p> <p>"A narcotic audit/count must be conducted at each change of shift to ensure against any discrepancy. The nurses involved will sign the Narcotic Check List. At the time of the audit/narcotic count the nurses are to observe for correct count and correct medication."</p> <p>B. 1. On 1/13/15 at 10:05 a.m. the medication cart on the locked dementia unit was observed with LPN #4. In the top drawer of the cart, the following over the counter medications and eye drops were observed: a box of sterile eye drops; Claritin tablets; Pain Relief Xtra (extra) 500 mg tablets; Fish Oil 1200 mg; Calcium 600 mg and vitamin D3 - 1000IU (international units); MVI (Multivitamin) One a Day Brand and Senna Laxatives 8.6 mg. LPN #4 verified at the time the above OTC medications were lacking physician names.</p> <p>On 1/13/15 at 10:50 a.m. the 300 hall cart was observed with LPN #6. The following over the counter (OTC)</p>		<p>administration log at the time she administered the medication- but failed to hand-sign out the pill on the individual count sheet in the paper narcotic log. The count sheet was corrected.No other residents were found to have been affected by the deficient practice.Locked Dementia Unit Medication Cart:The ordering physicians name was added to the label of the following OTC medications:Sterile Eye DropsClaritin TabletsPain Relief Xtra 500mg TabletsFish Oil 1200mgCalcium 600mgVitamin D3-1000IUMVI One a Day VitaminsSenna Laxatives 8.6mg300 Hall Medication Cart:The opened Peleverus Cream was disposed of.The Silvasorb Cream was labeled with the ordering physicians name.100 Hall Medication Cart:The OTC Aspirin was disposed of.The following OTC medications were relabeled with the physicians name:MagnesiumTwo bottles of Vitamin B12PurelaxVitamin D3 2000 IUComplete Multivitamin Women 50+AcetaminophenAspirin 325mg900 Hall Treatment CartThe Peleverus and Vera-serpine were disposed of.No other medications/creams were found to be lacking appropriate labeling.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</p>		

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	<p>medications were observed in the 2nd drawer of the cart with the documentation and/or labeling lacking of a resident's physician: 1 bottle each of Niacin 500 mg; ASA (aspirin) 81 mg; and "I Caps, 120 mg"; Tylenol Xtra (extra) strength 500 mg. In the third drawer were one bottle each of unopened Tylenol 500 mg and ASA 81 mg, which also lacked documentation of resident ' s physician name.</p> <p>On 1/13/15 at 11 a.m. the 300 hall treatment cart was observed with LPN #6. The following was observed: In the second drawer was an open tube of Peleverus and lacked documentation of a resident name; a tube of Silvasorb cream (a hydrogel silver antimicrobial wound gel treatment) lacked documentation of a physician name.</p> <p>B.2. During an observation of the 100 Hall Medication cart with LPN #8 on 1/13/15 at 10:20 a.m., the following was observed:</p> <p>- An OTC (Over The Counter) bottle of Aspirin (for pain or fever) 325 mg (milligrams) was not labeled with a Resident's name or Physician's name on the bottle.</p> <p>-An interview with LPN #8 on 1/13/15 at</p>		<p>taken:Residents residing in the facility with narcotic medication orders, utilizing OTC medications and those with physician orders for treatments consisting of creams have the potential to be affected by the alleged deficient practice. The medication/treatment carts have been audited to ensure all OTC and treatment creams are labeled appropriately.The Narcotic Count Logs have been audited to ensure on-coming/off-going nurses are counting the narcotics individually and consistently signing the shift to shift Count LogLicensed Staff have been re-educated on narcotic medication administration including procedure to sign out the medication when it is administered in both the electronic medication administration record and on the individual count logs for each resident. Education also included the requirement of the on-coming nurse and out-going nurse counting the narcotic medication vs. the count on the tracking log. Discrepancies are to be reported to the DNS immediately.Licensed Staff have been re-educated on labeling OTC medications and treatment creams. Education includes but is not limited to what information is required to be on the medication container label, information to be on the label of creams and separating individual creams into individual resident</p>				

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	<p>10:30 a.m., indicated the Aspirin should be labeled with the Resident's name.</p> <p>B.3. During an observation of the 100 Hall Medication Cart with RN #7 on 1/13/15 at 12:05 p.m., the following was observed:</p> <p>--An OTC bottle of Magnesium (a supplement) 250 mg tablets was without a physician's name labeled on the bottle.</p> <p>-Two OTC bottles of Vitamin B12 (a supplement) 100 mcg (micrograms) was without a physician's name labeled on the bottle.</p> <p>-An OTC bottle of Purelax (for constipation) was without a physician's name labeled on the bottle.</p> <p>-An OTC bottle of Vitamin D3 2000 IU (International Units, a measurement) was without a physician's name labeled on the bottle.</p> <p>-An OTC bottle of Complete Multivitamin Women 50+ (a supplement) was without a physician's name labeled on the bottle.</p> <p>-An OTC bottle of Acetaminophen (for pain or fever) 500 mg was without a physician's name on the bottle.</p>		<p>bags in the medication/treatment carts. Education provided by DNS/Clinical Education Co-ordinator/Designee by February 10, 2015. The Unit Managers are responsible for oversight. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: Licensed Staff have been re-educated on narcotic medication administration including procedure to sign out the medication when it is administered in both the electronic medication administration record and on the individual count logs for each resident. Education also included the requirement of the on-coming nurse and out-going nurse counting the narcotic medication vs. the count on the tracking log. Discrepancies are to be reported to the DNS immediately. Licensed Staff have been re-educated on labeling OTC medications and treatment creams. Education includes but is not limited to what information is required to be on the medication container label, information to be on the label of creams and separating individual creams into individual resident bags in the medication/treatment carts. Education provided by DNS/Clinical Education Co-ordinator/Designee by February 10, 2015. The DNS/Designee will audit the Medication/Treatment Carts daily</p>				

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	<p>-An OTC bottle of Aspirin (for pain or fever) 325 mg was without a physician's name labeled on the bottle.</p> <p>An interview with RN #7 on 1/13/15 at 12:20 p.m., indicated the Physician's name was not on the labels of the OTC medications. She also indicated the Resident's treatment creams and lotions from the Facility's stocked supplies were to be labeled with the Resident's name and an opened date and stored in a plastic zip-lock bag labeled with the Resident's name. She further indicated the treatment creams and lotions from the Facility's stocked supplies were not labeled with the physician's name.</p> <p>B.4. An observation of the 900 hall treatment cart on 1-13-2015 at 10:30 a.m. with LPN #5, indicated 2 opened and partially used tubes of Peleverus and Vera-serpine (topical barrier creams) were in the top right compartment of the treatment cart without a label to identify on which resident the barrier creams were used.</p> <p>An interview with LPN #5 on 1-13-2015 at 10:31 a.m., indicated both the Peleverus and Vera-serpine had been used for a resident, but the nurse was unable to identify which resident the</p>		<p>to ensure medications and treatments are labeled appropriately. The DNS/Designee will audit the narcotic count and shift to shift narcotic sign-off daily. The Unit Managers are responsible for oversight. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: CQI Monitoring Tools titled "Narcotic Administration and Reconciliation" and "Medication Labeling" will be utilized every week x 4, monthly x 6 and quarterly thereafter. Data will be submitted to the CQI Committee overseen by the Executive Director. If threshold of 95% is not met, an action plan will be developed. Non-compliance with facility procedures may result in disciplinary action up to and including termination.</p>	

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	<p>barrier creams belonged to.</p> <p>An interview with LPN #5 on 1-13-2015 at 12:23 p.m., indicated the topicals should have been labeled with the resident's name, date opened, the room number and a physician name.</p> <p>An interview with the Director of Nursing (DON) on 1-14-2015 at 8:50 a.m., indicated the topicals should have been labeled with the resident name. Further interview with the DON indicated the pharmacy tech last checked the carts on 11-19-2014 with a concern identified to label over the counter medications (OTC meds) with the resident name.</p> <p>A review of the pharmacy audit summary provided on 1-14-2015 at 8:50 a.m. by the DON indicated during the 11-19-2014 audit, the medication storage concerns were as follows: "...label all meds (OTCs, other pharmacies, etc) with Resident name...continue to spot check med carts...."</p> <p>A policy dated 7/2011, "Labeling of Medication" and provided by the DON on 1-14-2015 at 8:50 a.m., indicated the following: "To ensure all prescriptions are labeled in</p>			

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R000000	<p>accordance with state and federal regulations...labeling for all medications must be typed or printed and clearly indicate...resident/patient full name, prescription number, name and strength of the drug, route and time(s) the medication is to be given...quantity of drug/medication dispensed, date dispensed, expiration date of all time dated drugs, prescriber's name...."</p> <p>An interview with the DON on 1-14-2015 at 8:50 a.m. indicated the policy "Labeling of Medication" dated 7/2011 would include OTC medications. Further interview with the DON indicated the topical medications, Peleverus and Vera-serpine, would be on the physician orders.</p> <p>3.1-25(1) 3.1-25(1)(1) 3.1-25(1)(2)</p> <p>This visit was for an Initial State Residential Licensure Survey.</p> <p>Survey Date: January 15, 2015</p> <p>Facility Number: 000038 Provider Number: 155095 AIM Number: 100274830</p>	R000000	Heritage Park submits this response and Plan of Correction (POC) as part of the requirements under state and federal law. The POC is submitted in accordance with specific regulatory requirements. It shall not be construed as admission of any alleged	

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	<p>Survey Team: Martha Saull, RN TC Julie Call, RN Sue Brooker, RD Virginia Terveer, RN</p> <p>Census Bed Type: SNF: 19 SNF/NF: 144 Residential: 24 Total: 187</p> <p>Census Payor Type: Medicare: 21 Medicaid: 107 Other: 59 Total: 187</p> <p>Heritage Park Commons was found to be in compliance with 410 IAC 16.2-5 in regard to the Initial State Residential Licensure Survey.</p>		<p>deficiency cited or any liability. This provider submits this POC with the intention that it is inadmissible by any third party in any civil or criminal action proceedings against the provider or its employees, agents, officers or directors. This provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed findings are relied upon in a manner adverse to the interests of the provider either by the governmental agencies or third party. Any changes to provider policy or procedure should be considered to be subsequent remedial measures as the concept is employed in Rule 407 of the federal rules of evidence and should be inadmissible in any proceedings on that basis. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests paper compliance in lieu of a Post Survey Review on or after February 14, 2015.</p>		