

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2014
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the State Residential Licensure Survey.</p> <p>Survey Dates: August 5, 6, 7, 8, 11, and 12, 2014</p> <p>Facility Number: 000100 Provider Number: 155191 AIM Number: 100266130</p> <p>Survey Team: Jennifer E. Sartell, RN/TC Gloria J. Reisert, MSW Trudy Lytle, RN (August 5, 6, 7, 11 and 12, 2014)</p> <p>Census Bed Type: SNF/NF: 74 Residential: 92 Total: 166</p> <p>Census Payor Type: Medicare: 13 Medicaid: 58 Other: 95 Total: 166</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Dear Ms. Rhodes, Please find the form CMS-2567 with the plan of correction for the deficiencies cited during the Recertification and State Licensure Survey conducted at Westminster Healthcare Center on August 5, 2014 through August 12, 2014. I can be reached at 812-282-9691 ext. 123 if you would have any questions or comments regarding the enclosed documents. Sincerely, Floyd Shewmaker, Administrator Westminster Healthcare Center preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Healthcare Center (facility) is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute Westminster Healthcare Center allegation of Compliance. Date of Compliance by September 11, 2014.</p>	
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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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F000157 SS=D	<p>Quality Review completed on August 21, 2014, by Brenda Meredith, R.N.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member</p>			
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	<p>when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to notify the physician when a resident's blood sugars fell outside physician-designated parameters for notification. This deficient practice affected 1 of 1 diabetics reviewed for blood sugar monitoring. (Resident #67)</p> <p>Finding included:</p> <p>The clinical record for Resident #67 was reviewed on 8/7/14 at 2:40 p.m. The resident was admitted to the facility on 6/5/14 and was subsequently transferred back to the hospital on 6/19/14. The diagnoses included insulin dependent diabetes mellitus and dementia.</p> <p>The 6/5/14 physician admitting orders from the hospital indicated: "If glucose level is less than 60 or greater than 450, call MD unless otherwise specified."</p> <p>A nurses note, dated 6/15/14 at 0200 (2:00 a.m.), indicated: "Res [Resident] states ' I think my food has ran out.'</p>	F000157	<p>F 157 NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ECT) Please consider paper compliance for F-157. Corrective action taken for resident #67. Resident #67 has been discharged from facility. To prevent this deficiency practice from happening again. Initially all resident MARS were audited by Unit Coordinators with no residents identified as having same deficient practice. I. Director of Nursing spoke with Medical Director regarding all diabetics in facility. Medical Director has clarified order to state if blood sugar is less than 60 and greater than 450, notify physician unless physician orders state otherwise. II. Pharmedica to provide in-service on 09/04/2014 on medication documentation. All licensed staff, including QMA's, to be in-serviced by 09/09/2014. III. Audits of glucose log will be performed by Unit Coordinators 3 times per week to verify compliance for 2 weeks. Weekly checks by house supervisor for compliance for 2 weeks.</p>	09/11/2014

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F000282 SS=D	<p>Sugar/chemstick check done = 48. Res continues to talk with staff and is able to take snacks and fluids without difficulty. Sat with resident." At 0300 (3:00 a.m.), the nursing note indicated: "Accucheck/chemstick = 68. Res states 'I feel better'. Call bell within reach and res is able to use. PRN [as needed] snack [cookies] given."</p> <p>Documentation was lacking of the physician having been notified of the low blood sugar reading.</p> <p>During an interview, on 8/8/14 at 8:25 a.m., LPN #1 indicated "We usually follow the parameters of below 60 and above 450 when notifying the MD of accucheck results."</p> <p>3.1-5(a)(3)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure medications</p>	F000282	<p>Director of Nursing or designee appointed by Director of Nursing will audit logs monthly and as needed. This audit will be put in place as permanent tool to maintain compliance. IV. All findings out of compliance will be brought to monthly Quality Assurance meeting to be discussed and reviewed with appropriate recommendations. If audits are not in compliance, new interventions will be discussed.V. Completion date: 9/11/2014</p> <p>F-282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Please consider</p>	09/11/2014			

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	<p>were given, vital signs and accuchecks (blood sugar level checks) were completed prior to medication administration as prescribed by the physician for 1 of 2 residents reviewed for hospitalization. (Resident #67)</p> <p>Finding included:</p> <p>The clinical record for Resident #67 was reviewed on 8/7/14 at 2:40 p.m. The resident was admitted to the facility on 6/5/14 and subsequently transferred back to the hospital on 6/19/14. The diagnoses included insulin dependent diabetes mellitus, hypertension, dementia, atrial fibrillation, chronic obstructive pulmonary disease, pleural effusions and coronary artery disease.</p> <p>The 6/5/14 physician admitting orders from the hospital indicated: "If glucose level is less than 60 or greater than 450, call MD unless otherwise specified."</p> <p>The 6/5/14 Admitting physicians orders from the hospital included, but was not limited to the following medications and vital signs to be obtained daily: - Accuchecks AC (before meals) and HS (at bedtime) with sliding scale Humalog (insulin) - 6:30 a.m., 11:30 a.m., 4:30 p.m. and 8:00 p.m.</p>		<p>paper compliance for tag F-282. Corrective action taken for resident #67. Resident #67 has been discharged from facility. To prevent any future deficient practices from happening: I. Nursing staff will document all medication and vital signs as ordered.II. Director of Nursing and Staff Development Coordinator provided in-service on 8/26/2014 regarding documentation in nursing notes, MARS, and TARS. Staff educated on correct documentation for licensed staff and QMA. All staff will be in-serviced by 9/11/2014. Pharmacia to provide in-service on 9/4/2014 on documentation of medication, vital signs, and correct way to document on MARS and TAR if medication and vital signs not completed. III. All residents MARS have been audited and no other residents have been identified as having same deficient practice. Unit Coordinators to monitor MARS/TARS for any missed medications or vital signs 3 times a week for one month and as needed there after. House supervisors to monitor weekly for one month and as need there after. Director of Nursing to check MARS/TARS bi-weekly for one month and as neede there after. Unit Coordinators will continue to check weekly. Any missed vital signs/medications will be brought to Director of</p>	

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	<p>- Potassium Chloride 20 mEq (milliequivalent) - (to replace potassium lost during urination often associated with blood pressure medications) - 1 tablet by mouth BID (twice daily)</p> <p>- Clonidine 0.2 mg (milligram) (for Blood pressure) - give 1 tablet by mouth every day - hold for SBP (systolic blood pressure) less than 100 or HR (heart rate) of less than 60.</p> <p>- Metoprolol 100 mg (for blood pressure) - 1 tablet by mouth BID - hold for SBP less than 100 or HR less than 60.</p> <p>Review of the June 2014 Medication Administration Records (MARs) indicated the following accuchecks, blood pressure/pulse monitoring and medications were not provided as ordered by the physician: Accuchecks: -6/10 and 6/15 at 6:30 a.m. -6/12 at 11:30 a.m. and 4:30 p.m.</p> <p>Potassium Chloride: -6/11, 6/12, and 6/13 not given</p> <p>Clonidine: -6/10 and 6/11, blood pressure and pulse also not taken.</p> <p>Metoprolol:</p>		<p>Nursing attention with appropriate action to be taken. IV. Monitor MARS/TARS for resident compliance and review in monthly Quality Assurance meeting. V. Completion date: 09/11/2014</p>	

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F000329 SS=D	<p>6/12 - 9:00 a.m. dose - blood pressure and pulse also not taken 6/8, 6/9 and 6/17 the 9:00 p.m. dose - blood pressure and pulse also not taken</p> <p>Review of the nursing notes and the back of the MARs between 6/5 and 6/19/14 lacked this documentation.</p> <p>During the final exit meeting with the facility department heads on 8/12/14 at 5:30 p.m., the Director of Nursing indicated there should have been documentation on the back of the MAR or nursing notes as to why the medication was not given or vital signs/monitoring not obtained per physician order.</p> <p>3.1-35(g)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic</p>			

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	<p>drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to monitor the resident's sleep patterns prior to use of a routine hypnotic and to monitor and complete gradual dose reductions. This deficient practice affected 1 of 5 residents reviewed for unnecessary medications (Resident #11)</p> <p>Finding included:</p> <p>The clinical record for Resident #11 was reviewed on 8/11/14 at 1:54 p.m. The resident had diagnoses which included, but were not limited to: recurrent depressive psychosis, anxiety state, dementia with behavior disturbance.</p> <p>The August 2014 Monthly Physician Orders included, but were not limited to the following:</p> <ul style="list-style-type: none"> - 7/9/13 Lexapro 20 mg (milligrams)- 1 tablet QD (every day) - depression - 8/5/13 Cymbalta 30 mg - 1 tab QD - depression - 12/9/13 Ambien 10 mg 1 Q (every) HS (nightly) - insomnia 	F000329	<p>F-329 DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Please consider paper compliance for F-329. Corrective action taken for resident # 11. Resident #11 has been discharged from facility. To prevent any future deficient practices: I. Weekly meetings will be held by Director of Nursing or designee with Social Services, Unit Coordinators, or any staff appointed by director of Nursing, alternating units weekly, to discuss behaviors and medications that include hypnotics, sedatives, psychotropics, depressants, and antianxiety medications. II. Pharmacist to attend quarterly meeting of gradual dosage reduction. Pharmacy consultant reports to come to Director of Nursing. Unit Coordinators, House Supervisors, and Charge Nurses will send gradual reduction dosage to doctors. A log of residents on those pertinent drugs will be mentioned by the Unit Coordinators and the logs will be audited for dates of gradual dosage reductions sent and compliance weekly. The</p>	09/11/2014

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	<p>On 2/5/14, the Consultant Pharmacist made the recommendation for the Lexapro, Cymbalta, Ambien to be considered for gradual dose reduction for the lowest possible effective/optimal dose.</p> <p>Review of the 4/21/14 Quarterly Minimum Data Set Assessment (MDS) and the 7/14/14 Significant Change MDS Assessment indicated the resident had no issues with sleep. Documentation was lacking of the resident having been assessed and monitored as to why she needed a routine hypnotic.</p> <p>The MDSs' also indicated that the only mood issue the resident was experiencing was an occasional poor appetite during the July review.</p> <p>Psychiatrist notes between 12/4/13 and 7/7/14 failed to note the resident had been experiencing any mood (including sleep) or behavior problems per staff reporting.</p> <p>During an interview with the Social Worker on 8/11/14 at 2:20 p.m., she indicated that the resident had come from another nursing facility and that she was not sure if Gradual Dose Reductions were done there and if the facility was not</p>		<p>results of this audit will be reported to monthly Quality Assurance Committee. If no response within 5 days, Director of Nursing will call physician. Medical Director will be notified if no response in 2 business days from physician. III. Pharmerica to in-service all licensed staff and QMA's on documentation of theses types of medications on 09/04/2014. Pharmerica to review gradual dosage reduction request with staff. IV. All gradual dosage reductions will be discussed weekly in Behavior/pyschotropic Drug Meeting. Any gradual dosage reductions not complete will be discussed at monthly Quality Assurance Meeting by Director of Nursing/designee and new action plans and interventions will be established.</p>				

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F000428 SS=D	<p>supposed to reduce anything."</p> <p>On 8/11/14 at 2:57 p.m., the Social Worker presented a copy of the facility's current policy titled "Medication Monitoring/Medication Management". Review of the policy at this time included, but was not limited to: "...Guidelines for Psychotherapeutic Medication Monitoring: 1. Anti-psychotics:...Tapering of a medication gradual dose reduction (GDR): Within the first year in which a resident is admitted on an antipsychotic medication or after the nursing center has initiated an antipsychotic medication, the nursing care center must attempt a GDR in 2 separate quarters...2. Sedatives/Hypnotics: a. Taper considerations: For as long as a resident remains on a sedative/hypnotic that is used routinely and beyond the manufacturer's recommendations for duration of use, the nursing care center should attempt to taper the medication quarterly...."</p> <p>3.1-48(a)(6)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p>			

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	<p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure Consultant Pharmacy recommendations were acted upon in a timely manner for 1 of 5 residents reviewed for unnecessary medications. (Resident # 19)</p> <p>Finding includes:</p> <p>On 8/7/14 at 11:00 a.m., the clinical record for Resident #19 was reviewed. Diagnoses included, but were not limited to, coronary artery disease, dementia and depression.</p> <p>The Minimum Data Set Quarterly assessment, dated 7/3/14, was reviewed on 08/07/2014 11:38 a.m. which indicated an extensive one person physical assist with bed mobility, transfers, toileting and personal hygiene. It also indicated resident had no mood or behaviors.</p> <p>Record review on 8/7/14 at 12:45 p.m. indicated Resident #19 had been on Paxil since November of 2012. There were no Gradual Dose Reductions (GDR's) for the resident in the chart. The Medication Regimen Review, dated 11/21/13 and</p>	F000428	<p>F-428 DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON Please consider paper compliance for F-428. Corrective action taken for resident #19. Resident #19 has been discharged from facility. To prevent this deficient practice from happening in the future, measure put in place: I. Weekly meeting to be held by Director of Nursing or designee with Social Services, Unit Coordinators, or any staff appointed by Director of Nursing. Meetings will alternate weekly to ensure all residents on these medications are discussed twice a month. This meeting will be added to our weekly behavior meeting. It will be an ongoing proactice to ensure compliance is met and that no medications or residents are missed. Residents on any psychotropic, hypnotic, anti depressant, anti anxiety medications to be kept on log identifying medication and diagnosis. II. Pharmacy consultant reports to come to Director of Nursing. Physician to be faxed request. If no response within 5 business days, Director of Nursing will call physicians office. If no response in 2 business days, Medical Director will be notified. A log of residents</p>	09/11/2014

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	<p>6/3/14, indicated the pharmacist had made recommendations for Paxil. There were no nurses notes for those days.</p> <p>During an interview on 8/7/14 at 1:25 p.m., LPN #2 indicated that GDR's are done every 6 months unless the physician feels it would not be beneficial. She also indicated she could not find a GDR in Resident #19's chart.</p> <p>During an interview on 8/7/14 at 1:30 p.m., the Director of Nursing (DON) indicated Resident #19 was not seen by a psychiatrist and she had sent the pharmacy recommendation regarding Paxil to the residents' Primary Care Physician (PCP), which was still pending.</p> <p>On 8/7/14 at 2:00 p.m., the DON indicated the physicians office did not have the pharmacy recommendation for Resident #19 and she would have to fax it back over to the physicians office.</p> <p>On 8/8/14 at 11:40 a.m. the DON provided an original copy of a pharmacy recommendation titled "Note To Attending Physician/Prescriber", dated 6/3/14. It included, but was not limited to, the following: "Dear [physicians' name], This resident has been on <<Paxil 20 mg [milligrams] po [by mouth] qd</p>		<p>on those pertinent drugs will be mentioned by the Unit Coordinators and the logs will be audited for dates of gradual dosage reductions sent and compliance weekly. The results of this audit will be reported to monthly Quality Assurance Committee.III. Pharmerica to in-service staff on 9/4/2014 on medications, gradual dosage reduction, behavior sheets, and documentation. All staff in-service to be completed by 9/11/2014. IV. Psychiatrist to be reeducated on state requirements for attempting gradual dosage reduction to ensure guidelines are followed. V. All gradual dosage reductions will be discussed weekly in Behavior/pyschotropic Drug Meeting. Any gradual dosage reductions not complete will be discussed at monthly Quality Assurance Meeting by Director of Nursing/designee and new action plans and interventions will be established.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2014
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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	<p>[every day]>> (sic) since <<11-12-12>> (sic). Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose...Please check the appropriate response and add additional information as requested..." The Physician/Prescriber Response was blank.</p> <p>During an interview on 8/11/14 at 9:25 a.m., LPN #3 indicated an appropriate response time for pharmacy recommendations by the physicians was no later than the end of a shift it was faxed on. She also indicated if there was no response from the physician by 6:30 p.m., they call the number on the card located at the nurses station with the physician direct line number on it.</p> <p>On 8/11/14 at 10:54 a.m., MR#1 provided a copy of a pharmacy recommendation titled "Note To Attending Physician/Prescriber, dated 11/21/13. It included, but was not limited to the following: "Dear (physicians' name), This resident has been on Paxil 20mg daily for over a year. Please evaluate the current dose and consider a gradual taper to ensure this resident is using the lowest possible effective/optimal dose". It also indicated PCP wished to continue with the current</p>			

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129			
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F000431 SS=D	<p>dose. The Physician/Prescriber Response was signed and dated 1/14/14.</p> <p>During at interview on 8/11/14 at 11:45 a.m., the DON indicated an appropriate response time for pharmacy recommendations should be no more that a week. She also indicated it should really be sooner than that.</p> <p>3.1-25(i)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & 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,</p>						

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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	<p>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> <p>Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled. This deficient practice was based on 4 of 4 medication carts and 2 of 2 medication rooms observed. (Residents #6, 7, 9,14, 19, 25, 30, 43, 44, 46, 57, 59, 55, 59, 72, 80, 84, 101, 102, 109, 115, 141, 144).</p> <p>Findings included:</p> <p>1. During observation of the SNF (Skilled Nursing Facility) Short Hall medication cart on 8/11/14 at 10:35 a.m. while accompanied by QMA # 1 (Qualified Medication Assistant), the following was observed:</p> <p>a. Resident #6 - a bottle of Milk of Magnesia and Megatrol Acetate 40 mg/ml (milligram/milliliter) susp (suspension) did not have an opened date.</p> <p>b. Resident #30 - a bottle of Tussin DM Liquid did not have an opened date.</p> <p>c. Resident #144 - a bottle of Phenaseptic</p>	F000431	<p>F-431 DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Please accept paper compliance for F-431. Corrective action taken for residents # 6,7,9,14,19,25,30,43,44,46,57,72, 80,84,101,102,109,115,141,144. All residents noted above have been discharged from facility. To prevent deficient practices these measures have been put in place. Complete cart audit conducted. I. Director of Nursing and Staff Development Coordinator gave in-service on 8/26/2014 to licensed staff and QMA's on proper dating of opened medications, disposal of discharged or expired medications, and accurate way to complete medication reconciliation form. All licensed staff and QMA's to look for expired or undated medications on cart as medication pass is completed daily. II. Night shift nurses will check carts nightly for expired, discharged residents, and discharged medications over 30 days. Night shift nurses will be responsible for pulling medications off cart and</p>	09/11/2014

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129		
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	<p>1.4% spray and Fluticasone 0.05% nasal spray did not have an opened date.</p> <p>During an interview with the QMA at this time, she indicated: "An open date label is right on the packages/bottles - as soon as we open something, a date is supposed to be written on it."</p> <p>2. During observation of the SNF (Skilled Nursing Facility) Long Hall medication cart on 8/11/14 at 10:50 a.m. while accompanied by LPN #7, the following was observed:</p> <p>a. Resident #9 -Erythromycin oph (eye) oint (ointment) 4 gn (gram) and Miralax powder 17 gm not have an opened date.</p> <p>b. Resident #46 - Advair HFA 115-21 mcg (micrograms) inhaler did not have an opened date.</p> <p>c. Resident #72 - Nitrostate 0.4 mg tab sl (sublingual), Carafate 1 gm/10 ml suspension, Polyethylene Glycol 3350 powder, and - Chlore Hexidine 0/12% oral rinse - did not have opened dates.</p> <p>d. Resident 101 - Polyethylene Glycol 3350 powder did not have an opened date.</p> <p>e. Resident #25 - Ventolin hHFA 90 mcg inhaler - LPN #7 indicated that this</p>		<p>completing medication return sheet. Unit Coordinators to complete medication cart audits and medication room 3 times weekly for 1 month. House supervisor will complete weekly cart audits continuously as part of their job duties. Director of Nursing to review audits and address any issues identified in monthly Quality Assurance meeting. III. In the event of an emergency or any situation that would prevent the audit to not be completed, Unit Coordinators would then be responsible to complete task upon arrival to facility. IV. 19 of the 20 residents have been discharged home and their medications should have been discarded or returned to the pharmacy. 1 resident is still an existing resident and their medication should have been returned to the pharmacy.V. Completion date: 9/11/2014</p>		

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129			
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	<p>resident had passed away about a week ago and that the medications just had not been removed yet.</p> <p>f. Resident #14 - Nitrostat 0.4 mg tab sl had no opened date. The Glucagen 1 mg hypokit in the bottom drawer with the resident's name on it had an expiration date of 6/14. The LPN indicated at this time that the resident was no longer a healthcare resident as she had returned to Assisted Living about 3 weeks ago.</p> <p>3. During an observation of the ICF (Intermediate Care Facility) Short hall at 11:05 a.m. while accompanied by LPN #1, the following was observed:</p> <p>a. Resident #49 - Prolensa 0.07% eye drops, Nitrostat 0.4 mg tab sl, Iprat-Albut 0.5-3 (2.5) mg/3 ml, Fluticasone prop 50 mcg spray did not have opened dates on them.</p> <p>b. Resident #59 - Iprat-Albut 0.5-3 (2.5) mg/3 ml did not have an opened date.</p> <p>c. Resident #84 - Fluticasone prop 50 mcg spray did not have an opened date.</p> <p>d. Resident #7 - Polyethylene Glycol 3350 powder did not have an opened date.</p> <p>e. Resident #141 Polyethylene Glycol</p>						

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129		
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	<p>3350 powder did not have an opened date.</p> <p>f. Resident #80 - Milk of Magnesia Suspension did not have an opened date.</p> <p>During an interview with the LPN during this time, she indicated that medications were supposed to have an open date on them.</p> <p>4. During an observation of the ICF (Intermediate Care Facility) Long hall at 11:15 a.m. while accompanied by LPN #8, the following was observed:</p> <p>a. Resident #43 - Polyethylene Glycol 3350 powder - did not have an opened date.</p> <p>b. Resident #19 - Polyethylene Glycol 3350 powder - did not have an opened date.</p> <p>c. Resident # 55 - Robitussin Mucus and Chest liquid - did not have an opened date.</p> <p>d. Resident #115 - Levetiracetam 100 mg/ml solution, Citalopram HBR 10 mg/5 ml soln, MAPAP 160 mg/ml elixer (pain medication), and Ondansetron 4 mg/5 ml soln did not have opened dates on them.</p>				

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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	<p>e. Resident #44 - Iprat-Albut 0.5-3(2.5) mg/3 ml did not have an opened date.</p> <p>f. Resident #77 - Ipratropium BR 0.02% soln and Albuterol 0.083% inh soln did not have opened dates.</p> <p>g. Resident #109 - Iprat-albut 0.5-3(2.5) mg/3 ml soln did not have an opened date.</p> <p>5. During an observation of the ICF medication room refrigerator at 11:25 a.m. while accompanied by LPN #1, the following was observed:</p> <p>a. Resident #115 - Omeprazole 2 mg/ml susp 200 ml did not have an opened date.</p> <p>b. Resident #40 - an opened vial of Humalog Insulin soln .</p> <p>c. Resident #102 - Forteo Sol 600/2.4 3 ml had no opened date.</p> <p>6. During an observation of the SNF medication room refrigerator at 11:39 a.m. while accompanied by LPN #7, the following was observed:</p> <p>a. Resident #112 - an IV (intravenous) bag of Vancomycin CHL1250 mg was observed directly underneath the small freezer compartment and was frozen solid. An interview with the LPN at this time indicated that she guessed she would</p>			

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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R000000	<p>need to throw it away and was unable to account as to how long it had been in the refrigerator.</p> <p>On 8/11/14 at 2:00 p.m., the Director of Nursing presented a copy of the facility's current policy titled "Labeling of Medications". Review of this policy at this time included, but were not limited to: "Purpose: The purpose of this procedure is to ensure that all medications maintained in the facility are properly labeled in accordance with current state and federal regulations...." The policy failed to address the issue of an open date when over the counter, eye drops, nasal spray and topical medications were opened.</p> <p>3.1-25(j) 3.1-25(o)</p> <p>The following State Residential findings are cited in accordance with 410 IAC 16.2-5.</p>	R000000	<p>Dear Ms. Rhodes, Please find the form CMS-2567 with the plan of correction for the deficiencies sited during the Recertification and State Licensure Survey conducted at Westminster Healthcare Center on August 5, 2014 through August 12, 2014. I can be reached at 812-282-9691 ext. 123 if you would have any questions or comments regarding the enclosed documents. Sincerely, Floyd</p>	

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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R000092	<p>410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance</p> <p>(i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:</p> <p>(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be</p>		<p>Shewmaker, Administrator Westminster Healthcare Center preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the provisions of federal and state law. Allegation of Compliance: For the purposes of any allegation the Westminster Healthcare Center (facility) is not in substantial compliance with federal requirements of participation, this response and plan of correction constitute Westminster Healthcare Center allegation of Compliance. Date of Compliance by September 11, 2014.</p>	

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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	<p>held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms.</p> <p>(2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present.</p> <p>Based on record review and interview, the facility failed to attempt fire/disaster drills with the local fire department. This deficient practice had the potential to effect 95 out of 95 residents residing in Residential.</p> <p>Findings include:</p> <p>On 8/12/14 at 3:45 p.m., review of the facility fire drills indicated 12 drills were conducted quarterly on each shift. There was no documentation pertaining to fire and disaster drills conducted with the local fire department.</p> <p>On 8/12/14 at 4:00 p.m., the Maintenance Director indicated the local fire department used the facility for training purposes to practice with new equipment acquired by the department and staff did not participate during that training. He also indicated he had not attempted to conduct a fire/disaster drill with the fire department.</p>	R000092	<p>R 092 ADMINISTRATION AND MANAGEMENT I. It is the policy of Westminster Assisted Living to ensure the safety of our residents and to ensure facility personnel are familiarized with signals and emergency action required in case of fire or disaster.. II. All residents have the potential to be affected by alleged deficient practice. Fire drill will be conducted monthly on alternating shifts. When fire drills are conducted monthly on alternating shifts. The maintenance director will attempt to hold a fire and disaster drill in conjunction with the local fire department every 6 months. A record will be documented in the fire and disaster manual of attempt made with local fire department to participate in drill . A record of all training and drills will be documented with the names and signatures of the personnel present. III. Audit of the fire and disaster manual will be completed quarterly by maintenance director/designee. Attempt will be made for fire department to participate in fire drill by</p>	09/11/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2014
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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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R000144	<p>410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.</p> <p>Based on observation and interview, the facility failed to ensure the vents and light fixtures were free of dust in 3 of 8 vents and 1 of 36 light covers.</p> <p>Findings include:</p> <p>1. On 08/12/14 at 2:55 p.m., during the tour of the facility with the Maintenance Director, one vent above a washing machine on the second floor resident's laundry room was noted to have dust collected in the internal filter of the vent. The Maintenance Director indicated the vent had recently been cleaned, but upon observing the vent himself, he indicated he could see the dust accumulation internally also and called one of his maintenance team to clean the vent again.</p> <p>2. On 08/12/14 at 4:20 p.m., during the tour of the second floor dining room, 2 of</p>	R000144	<p>9/11/2014. IV. Results of audits will be reported at the Quality Assurance Committee Meeting. If audits are not in compliance, new interventions will be discussed.V. Completion date: 9/11/2014 **We respectfully request that paper compliance be considered.</p> <p>R 144 Sanitation and Safety StandardsI. It is the policy of Westminster Assisted Living to ensure facility is in good repair and shall provide reasonable comfort for all residents.II. No residents were affected by alleged deficient practice. The vents, surrounding ceiling area and ceiling light cover was cleaned on the day of survey in the dining room by housekeeping staff on 8/12/2014. The inside of vent in the laundry room was cleaned immediately by maintenance staff on day of survey on 8/12/2014. The housekeeping staff will dust all ceiling vent covers and light fixtures daily in dining room. Housekeeping supervisor will audit weekly. Housekeeping staff will be in-serviced by 9/11/2014. Housekeeping Deep Cleaning policy was reviewed and revised. The ceiling vents were placed on a quarterly cleaning schedule to</p>	09/11/2014

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129			
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R000302	<p>7 vents were noted to have dust on the outside of the vent as well as dust on the ceiling around the vents in a circular pattern. The 2 vents were directly over the Resident's dining tables. Dust was also noted on 1 of 36 light covers over a dining room table.</p> <p>410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on record review and interview, the facility failed to ensure over the counter medications were properly labeled with resident identifying information and medications had open dates for 4 of 6 medication carts. (Residents #3, 5, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41 and 42)</p>	R000302	<p>be completed by maintenance staff. The maintenance staff will audit all ceiling vents for dust inside of vents and clean such vents throughout Assisted Living Facility by 9-11-2014. Maintenance staff will be in-service by 9/11/2014.III. Audit will be completed by Housekeeping supervisor/designee weekly. Maintenance Supervisor/designee will audit interior vents quarterly.IV. Results of all audits will be reported at the Quality Assurance Committee Meeting. If audits are not in compliance, new interventions will be discussed.V. Completion date: 9/11/2014.</p> <p>R 302 PHARMACEUTICAL SERVICESI. It is the policy of Westminster Assisted Living to ensure over-the-counter medications are marked with sticker properly upon receiving the medications.II. All residents have the potential to be affected by alleged deficient practice. The policy and procedure was revised for proper sticker on bottle and storage of over-the-counter</p>	09/11/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155191		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2014	
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	<p>Findings include:</p> <p>1. During observation of the 3rd floor medication cart #1 on 8/12/14 with LPN #4 at 1:15 p.m., the following was observed:</p> <p>a. Resident #3 - a bottle of Colace 100 mg (milligrams) and a bottle of Ibuprofen 200 mg was missing the resident's first name and the name of the physician.</p> <p>b. Resident #5 - bottle Afrin Nasal Spray, bottle of Tylenol Extra Strength pain reliever 500 mg (milligrams), a box of Align Probiotic Supplement, and bottle of Caltrate 600 mg D Calcium Supplement - all missing name of physician.</p> <p>c. Resident #9 - a bottle of Refresh Tears, Mucinex 600 mg, a bottle of Calcium 600 mg + Vitamin D3, and a bottle of Fish Oil 1200 mg were missing the physician's name; a bottle Zyrtec 10 mg was missing the first name of the resident and the physician name.</p> <p>d. Resident #10 - a bottle of Bayer Low Dose Aspirin 81 mg , Calcium 1200 mg + 1000 IU Vitamin D3, Centrum Silver Multivitamin, a bottle of C-1000 mg, and a bottle of Miralax - all missing the name of the physician.</p>		<p>medications. A sticker will be applied to all over-the-counter medication upon receiving medication before placing into resident's medication drawer in the medication cart. The sticker is not to cover the medication name, strength of medication, or expiration date. The sticker will include the resident's full name, resident's apartment number, physician's full name, and date opened. The expiration date date will be circled. All staff will be in-serviced by 9/11/2014.III. Audit will be completed on all medication carts with stickers applied to each over-the-counter medication by AL Director/designee. Audits will be conducted weekly by night shift licensed staff. Audits will be completed monthly by AL director/designee for 3 months, then as needed, to ensure proper sticker is accurate by AL Director/designee by September 11, 2014.IV. Results of all audits will be reported at the monthly Quality Assurance Committee Meeting. If audits are not in compliance, new interventions will be discussed.V. Completion date: 9/11/2014.**We respectfully request that paper compliance be considered.</p>				

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	<p>e. Resident #11 - a bottle of Equate Acetaminophen Extra Strength 500 mg was missing the name of the physician; a bottle of Pepto Bismol, Immodium AD, and Melatonin 5 mg - all missing the resident's last name and name of the physician.</p> <p>f. Resident #12 - a bottle Calcium 500 + D, a bottle of Senna - S 50 mg/8.6 mg, and a bottle of Bayer Chewable Low Dose Aspirin 81 mg - all missing name of physician.</p> <p>g. A bottle of Advil 200 mg - no identifying resident information on the bottle. LPN #4 was also unable to identify who the bottle belonged to.</p> <p>h. A bottle of Acetaminophen 325 mg pain reliever and a bottle of Magnesium 250 mg had no resident identifying information on them. Upon checking the Medication Administration Record book, LPN #4 indicated the medications belonged to Resident #15.</p> <p>i. Resident #16 - a bottle of Vitamin C 500 mg, Tylenol Extra Strength 500 mg, and a bottle of Tylenol Regular Strength 325 mg were missing the name of the physician. A bottle of Lumigan 0.01% solution had no open date on it.</p>			

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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	<p>j. Resident#17 - a bottle of Acetaminophen Extra Strength pain reliever 500 mg was missing the name of the physician.</p> <p>During this medication cart review, LPN #4 indicated that everyone was so confused as to what was supposed to be written on the bottle and had varying ideas.</p> <p>2. Review of 3rd floor medication cart #2 with LPN #4 on 8/12/14 at 1:35 p.m., the following was observed:</p> <p>a. Resident #18 - Artificial Tears Solution had no open date on it. A Bottle of Tylenol Extra Strength 500 mg and a a bottle of Lumigan 0.01% solution were missing the name of the physician.</p> <p>b. Resident #19 - a bottle of Advanced Lubricant eye drops did not have an open date and was missing the resident's first name and physician's name. A bottle of ES (extra strength) Acid 500 mg and Equate Allergy Relief 10 mg - missing the name of the physician.</p> <p>c. Resident #20 - a bottle of Fish Oil, MultiVites - Complete Multivitamin, Vitamin D-3, Ibuprofen 500 mg, Stool Softner, and Viactive Calcium D Chews - were missing the name of the physician. a</p>			

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	<p>bottle of Cranberry 500 mg had no resident identifying information on it. LPN #4 at this time identified it as belonging to this resident. A bottle of Aspirin 81 mg was missing the resident's first name and the name of the physician.</p> <p>d. Resident #21 a bottle of Prilosec OTC 20.6 mg had no resident identifying label on it. LPN #4 confirmed at this time that it belonged to this resident.</p> <p>e. Resident #22 - a bottle of Fish Oil 1000 mg, OsCal Calcium + D3 500 mg/200 IU were missing name of the physician.</p> <p>f. A bottle of Glucosamine 500 mg Chondrotin 250 mg had no resident identifying information on it. LPN#4 was unable to identify who it belonged to.</p> <p>g. Resident #23 - a bottle of Acid Reducer 75 mg and ES Pain Relief Acetaminophen 500 mg were missing the resident's first name and the name of the physician.</p> <p>h. Resident #24 - a bottle of Cheracol Sore Throat Pain 1.4% liquid was missing an open date.</p> <p>i. Resident #25 - Hydrocort AC Sup 25 mg was missing an open date.</p>			

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	<p>3. During the 2nd floor #1 Medication Cart with LPN #5 on 8/12/14 at 2:10 p.m., the following was observed:</p> <p>a. Resident #26 - a bottle of Low Dose Aspirin 81 mg, Anti-Diarrhea 2 mg, Tylenol Regular Strength 325 mg, Equate Nasal Spray, Lumigan 0.01% eye drops, Flaxseed Oil 1000 mg and Adult's MultiVitamin/Minerals were all missing the resident's first name. A bottle of D 1000 IU had no resident identifying information on it. LPN #5 identified this bottle as belonging to Resident #26 at this time.</p> <p>b. Resident #27 - a bottle of Alphagan 10 ml solution had no resident first name on it.</p> <p>c. Resident #28 - a bottle of OcuVite with Lutien had no resident identifying information label on it. LPN #5 identified this bottle as belonging to Resident #28.</p> <p>d. Resident #29 - a bottle of COQ - 10 and 2 bottles of D3 2000 IU were missing the resident's first name and name of physician. A bottle of Tylenol Regular Strength 325 mg had no resident identifying label on it. LPN #5 identified this bottle as belonging to this resident.</p> <p>e. Resident #30 - a bottle of Iron 65 mg,</p>			

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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	<p>Vitamin E 1000 IU, Fero Solfate 325 mg, Glucosamine 1500 mg Chondroitin 1200 mg, Vitamin D, Caltrate 600 + D3, and Vitamin E 1000 IU were all missing the first name of the resident and the name of the physician.</p> <p>f. Resident #31 - a bottle of Tums Ultra Strength 1000, Colace 100 mg, Align Probiotic, 24 hour Allergy 10 mg, ES Pain Relief 500 mg, Refresh Eye Drops, Macular Protect Complete - S were all missing the resident's first name. The bottle of Refresh Eye Drops was also missing an open date.</p> <p>g. Resident #32 - A bottle of Centrum Silver was missing the resident's first name and name of Physician. A bottle of Calcium 600 mg + Vitamin D 800 IU had no resident identifying information label on the bottle. LPN #5 identified this bottle as belonging to this resident.</p> <p>h. Resident #33 - a bottle of Complete Men's Senior Health, Zyrtec 10 mg, and Tylenol Regular Strength were all missing the first name of the resident and name of the physician. A bottle of Melatonin 3 mg had no physician's name.</p> <p>i. Resident #34 - a bottle of live Women's 50+ and Calcium 600 mg = Vitamin D were missing the resident's first name and</p>			

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	<p>name of the physician.</p> <p>4. During the observation of 1st floor Medication Cart #1 with LPN #6 at 2:43 p.m., the following was observed:</p> <p>a. Resident #36 - a bottle of ES Acetaminophen 500 mg, Benedryl 25 mg, and Bayer Low dose Aspirin 81 mg were missing the first name of the resident and the name of the physician.</p> <p>b. Resident #37 - a bottle of One Daily Multivitamins, Equate Allergy Relief 10 mg, Milk of Magnesia, and Gentle Lax Powder were missing the name of the physician.</p> <p>c. Resident #38 - Mucinex 600 mg box had no physician's name on it.</p> <p>d. Resident #39 - a bottle of regular Strength Acetaminophen 325 mg had no physician's name on it. The bottle of Milk of Magnesium had no open date on it.</p> <p>e. Resident #40 - a bottle of Polyethylene Glycol Powder 3350 and Milk of Magnesium had no open dates on them.</p> <p>f. Resident #41 - a bottle of Sodium Chloride Hypertonic 5% solution, Dorzolomaide - Timolol Opth 2% - 0.5 mg Solution, and Megastrol Acetate 40 mg/ml suspension all had no open dates</p>			

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NAME OF PROVIDER OR SUPPLIER WESTMINSTER HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2210 GREENTREE N CLARKSVILLE, IN 47129
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R000349	<p>on them.</p> <p>g. A bottle of Tylenol Regular Strength 325 mg and Bayer Low Dose Aspirin 81 mg had no resident identifying information labels on the bottle. LPN #6 identified these bottles as belonging to Resident #42.</p> <p>In an interview with LPN #6 during this medication cart check, she indicated that the protocol was to use a black marker to write the resident's name and room number on the bottle as soon as it was received from pharmacy or family and also place an open date sticker on the bottle with the date as to when the medication was opened.</p> <p>During the final exit meeting with the facility Department Heads on 8/12/14 at 5:30 p.m, the Assisted Living Unit Coordinator indicated that the staff had just been inserviced on what was supposed to be on the residents' medication bottles/labels so there should not have been any confusion.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that</p>			

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	<p>responsibility. The records must be as follows:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to ensure residents' clinical records were complete and accurate for 2 of 7 residents' reviewed for complete and accurate clinical records. (Resident #5 and Resident #6)</p> <p>Findings Included:</p> <p>1. On 8/12/14 at 3:00 p.m., the clinical record for Resident #5 was reviewed. Diagnoses included, but were not limited to, multiple sclerosis, hyperlipidemia, neurological disorder, anxiety, dementia and hypertension.</p> <p>On 8/12/14 at 3:10 p.m., review of resident #5's admission orders on 5/11/12 indicated no annual health statement. Physicians orders from May 2014 through August 2014 also indicated no annual health statement for Resident #5.2. On 08/12/14 at 3:25 p.m., the record review for Resident # 6 indicated no annual health statement in the closed chart.</p> <p>On 08/12/14 at 3:55 p.m., the LPN (Licensed Practical Nurse) #7 and the</p>	R000349	<p>R 349 CLINICAL RECORDSI. It is the policy of Westminster Assisted Living to ensure physician's admission order and monthly rewrites are complete and accurate clinical records.II. No residents were affected by alleged deficient practice. Pharmerica Pharmacy was notified immediately on 8/12/2014. The incident was reported to Pharmerica Pharmacy, medical records had deleted the statement "No evidence of TB in an infectious stage", from the monthly rewrites. Pharmerica Medical Record department reported when checking back through their records, the statement was present on all admissions and re-admissions orders. It was requested all September rewrites have the statement printed on rewrites before sending to facility. Monthly rewrites are to be monitored for accuracy by night shift licensed staff prior to the first day of each month. All physician medication orders, ancillary orders, physician name, allergies diagnoses and apartment number are to be verified against the previous monthly rewrite or admission orders and any new orders to ensure accurate clinical</p>	09/11/2014

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	Assisted Living Assistant Supervisor were unable to locate the annual health screen in Resident # 6's closed chart. They indicated this information was not apparently being printed by (Name on of Pharmacy) rewrites of the MAR, provided by the company. The LPN # 7 indicated she needed to show the Assisted Living Unit Coordinator this oversight.		records. All monthly rewrites are in compliance for the month of September. The policy for completion of monthly rewrites was reviewed and revised.III. All September 2014 rewrites have been audited by A/L director and are in compliance.Audits then will be conducted monthly by A/L director/designee for 3 months, then as needed. The night shiftlicensed staff will be in-serviced on proper procedure for completing monthly rewrites accurately by August 31, 2014. All licensed staff will be in-serviced by September 11, 2014.IV. Results of audits will be reported at the Quality Assurance Committee Meeting. If audits are not in compliance, new interventions will be discussed.V. Completion date September 11, 2014**We respectfully request that paper compliance be considered.		