

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/18/2013
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NAME OF PROVIDER OR SUPPLIER RITTENHOUSE SENIOR LIVING OF MICHIGAN CITY	STREET ADDRESS, CITY, STATE, ZIP CODE 4300 CLEVELAND RD MICHIGAN CITY, IN 46360
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: January 17 & 18, 2013</p> <p>Facility number: 012180 Provider number: 012180 AIM number: N/A</p> <p>Survey team: Lara Richards, RN., TC Heather Tuttle, RN. Kathleen "Kitty" Vargas, RN. (1/17/13)</p> <p>Census bed type: Residential: 77 Total: 77</p> <p>Census payor type: Other: 77 Total: 77</p> <p>Sample: 9</p> <p>These state residential findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 23, 2013, by Janelyn Kulik, RN.</p>	R0000	Please accept this as our credible allegation for Survey Event ID ZMC311	
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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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R0297	<p>410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana.</p> <p>Based on observation, record review and interview, the facility failed to ensure medication was administered according to the manufacture's recommendations related to Omeprazole (Prilosec-a medication used for gastric reflux) for 1 of 5 residents observed during medication pass. (Resident #9)</p> <p>Findings include:</p> <p>On 1/18/13 at 8:20 a.m., LPN #1 was observed preparing medications for Resident #9. At that time, the LPN poured the medication of Prilosec OTC (Omeprazole) 20 milligrams (mg) one capsule into the medication cup. She then proceeded to administer the medication to Resident #9.</p> <p>Interview with LPN #1 at the time, indicated the resident had already eaten breakfast. She further indicated breakfast was usually served around 7:30 a.m.</p>	R0297	<p>I. For Residents found to have been affected by the deficient practice we immediately began giving Prilosec with a glass of water before eating in the morning to take immediate corrective action.II. To identify other residents having the potential to be affected by the same deficient practice we audited all the charts to ensure any resident receiving Prilosec or other Proton Pump Inhibitors would have the medication administered before eating meals and with a glass of water. All nursing staff was in-seervised to ensure any resident receiving Prilosec or any other kind of Proton Pump Inhibitor would be given before meal and with a glass off water before eating in the morning.III. Sysemic changes to be put in Place to ensure that the deficient practice does not recur will include monthly monitoring for 6 months and indefinite, random monitoring following the 6 monthe period. Also, the attached in-service will be added to our anynal in-services for nursing staff.IV.</p>	02/15/2013			

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	<p>The record for Resident #9 was reviewed on 1/18/13 at 8:30 a.m. The resident's diagnoses included, but were not limited to, gastric reflux disease.</p> <p>Review of the Medication Administration Record (MAR) for 1/13, indicated the resident was to receive Omeprazole 20 mg one capsule in the a.m.</p> <p>Review of the information from the website www.PrilosecOTC.com on 1/18/13 at 3:12 p.m., indicated under the tab Warnings and Directions the medication was to be given with a glass of water before eating in the morning.</p> <p>Interview with LPN #1 on 1/18/13 at 8:30 a.m., indicated "a.m." meant the resident could receive the medication anytime between 6:00 a.m., and 10:00 a.m. She further indicated she was unaware the Omeprazole was to be given before meals.</p>		<p>Please see attached monthly monitoring form to be completed by the Resident Care Director or Designee for 6 months and the random monitoring indefinitely to follow. Also, the attached in-service will be included annually for nursing's annual in-services for quality assurance. Monitoring forms and annual in-services will be monitored by the Executive Director for monitoring monthly and annually as well.V. February 15 2013</p>	

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R0306	<p>410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug.</p> <p>Based on record review and interview, the facility failed to ensure medication disposition was documented for 2 of 2 closed records reviewed in the sample of 9. (Residents #6 & #7)</p> <p>Findings include:</p> <p>1. The closed record for Resident #6 was reviewed on 1/18/13 at 9:20 a.m. Documentation in the Nursing progress notes dated 8/9/12 at 9:15 p.m., indicated the resident had fallen and he was being sent to the Emergency room for evaluation. The resident was admitted to the hospital. After the resident's hospital stay, he</p>	R0306	I. For Resdients found to have been affected by the deficient practice and for immediate corrective action we in-serviced nursing staff regarding State and Federal Laws on disposition of any released, returned, or destroyed medication and the proper documentation on the Resident's clinical record to include all 9 points from State, Federal, andLocal laws. (please see attached) Also, this in-service will be added to our annual in-service for nursing.II. to identify other Residents haveing the potential to be affected by the same deficient practice immediate corrective action through nursing in-servicing was completed. The Resident Care Director will monitor the deficient	02/15/2013			

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	<p>was transferred to a long term care facility.</p> <p>There was no documentation in the resident's record related to the disposition of his medications.</p> <p>Interview with the Resident Care Director on 1/18/13 at 10:00 a.m., indicated the resident's medications had been disposed of but no documentation had been completed.</p> <p>2. Review of the closed record for Resident #7 on 1/18/13 at 9:27 a.m., indicated the resident was discharged from the facility on 11/24/12.</p> <p>Review of the 11/12 Medication Administration Record (MAR), indicated the resident was receiving Elavil (an anti-depressant) 100 milligrams (mg) one tablet at night time, Toprol XL (a blood pressure medication) 50 mg daily, Diazide</p>		<p>practice for 6 months and randomly, indefinitely, following the 6 month monitoring period. please see attached monitoring form.III. Systemic changes to be put in place to insure the deficient practice does not recur will include monthly monitoring for 6 months and indefinite, random monitoring following. Also, the attached in-service will be added to our annual in-services for destruction of medications and completed forms for nursing.IV. Please see attached monthly monitoring form to be completed by the Resident Care Director or Designee for 6 months and random, monitoring indefinitely to follow. Also, the attached in-service will be included annually for nursing annual in-services for quality assurance. Monitoring form and anynal in-services will be moniotred by the Executive Director monthly and annually as well.V. February 15, 2013</p>				

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	<p>(a water pill) 37.5-25 mg daily, Coreg (a blood pressure medication) 12.5 mg twice a day, Risperdal (an anti-psychotic medication) 1 mg twice a day, and Valium (an anti-anxiety medication) 5 mg three times a day.</p> <p>Further record review indicated a medication disposition form after the resident was discharged from the facility was not available for review.</p> <p>Interview with the Resident Care Director on 1/18/13 at 10:20 a.m., indicated the resident was discharged to home and took all of her medications with her. She further indicated there was no medication disposition form completed indicating where the medications were displaced after the resident was discharged.</p>						

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R0349	<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 responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to physician notification and discharge instructions for 2 of 7 records reviewed in the sample of 9. (Residents #1 & #7)</p> <p>Findings include:</p> <p>1. The record for Resident #1 was reviewed on 1/17/13 at 1:30 p.m. An entry in the Nursing progress notes dated 12/2/12 at 9:45 a.m., indicated the resident had a red rash and itching to the right side of his back. The doctor was to be contacted.</p> <p>The next documented entry on 12/4/12 at 8:00 a.m., 48 hours later, indicated the resident's daughter was notified of the rash and asked how she wanted to proceed, take to a doctor or notify his primary care</p>	R0349	<p>I. The corrective actions to be immediately accomplished for those residents found to have been affected by the deficient practice were as follows: A nursing in-service on Timely Physicians Notification, Discharge Instruction will be completed by all nursing staff. The Resident Care Director is designated with the responsibility of Clinical Records Completeness along with the oversight of the Executive Director for the above mentioned resident records. The resident record will be complete, accurately documented, readily accessible and systematically organized.II. To identify any potential problems concerning Physicians Notification, or Discharge Instruction and/or completion an audit of all resident medial records with concerns requiring Physician Notification or Discharge Instruction will be completed to ensure ongoing compliance with State, Federal and Local laws. (Please see attached Discharge Summary</p>	02/15/2013			

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	<p>physician? The daughter indicated that she would like Dr. (physician's name) to take over the resident's care. The physician was notified of the family's desire for him to take over the resident's care and he was also notified of the resident's rash.</p> <p>The next documented entry on 12/7/12 at 2:00 p.m., 72 hours later, indicated follow up was completed with the physician to see if he was going to take over as the resident's physician and the resident's rash. Documentation indicated there was no response from the physician.</p> <p>Documentation on 12/10/12, no time, indicated the resident's previous physician was notified of the rash. New orders were received related to the rash on 12/11/12.</p> <p>Interview with LPN #2 on 1/18/13 at 10:30 a.m., indicated that she faxed the physician on 12/7/12, which was a Friday, and she would not have expected a response from him prior to Monday.</p> <p>Interview with the Resident Care Director on 1/18/13 at 11:00 a.m., indicated that documentation should have been completed in a more timely manner related to the</p>		<p>Form for Discharge Instruction.)III. Systemic changes to be put in place to ensure the deficient practice does not recur will include monthly monitoring for 6 months and indefinite, random monitoring following. Also, the attached in-service will be added to our annual in-service for nursing staff indefinitely.IV. Please see attached monthly monitoring form to be completed by the Resident Care Director or Designee for 6 months and random monitoring indefinitely to follow. Also, the attached in-service will be included annually for nursing's annual in-services for quality assurance. Monitoring forms and annual in-services will be monitored by the Executive Director for monitoring monthly and annually as well.V. February 15, 2013.</p>				

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	<p>Physician's response of the rash and his taking over care of the resident.</p> <p>2. Review of the closed record for Resident #7 on 1/18/13 at 9:27 a.m., indicated the resident was discharged from the facility on 11/24/12.</p> <p>Review of the Discharge Summary, indicated under follow up and Discharge Medication (instructions to patient), and rehab potential were incomplete and blank. There was no evidence of documentation the resident's medications were listed. Further review of the Discharge Summary, indicated the address where the resident was going was also incomplete.</p> <p>There was no evidence of documentation of continuity of care from the facility to the resident's discharge location.</p> <p>Review of the current 12/2/2009 Moving Out Process provided by the Resident Care Director indicated "Residents and family members of (Facility name) will be provided with coordinated move-out process to provide the resident and family with uninterrupted services."</p> <p>Interview with the Resident Care Director on 1/18/13 at 11:40 a.m., indicated the Discharge Summary was the discharge instructions that were to be given to</p>			

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	residents when they leave the facility. She further indicated the Discharge Summary was incomplete for Resident #7.				