STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF CARMEL	11610 TECHNOLOGY DR CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for the Investigation of Complaint IN00148969. Complaint IN00148969 Substantiated. State deficiencies related to the allegations are cited at R0036, R0148, R0241, 0247 and R0301. Survey Dates: July 2 & 3, 2014 Facility number: 012309 Provider number: NA AIM number: NA Survey Team: Mary Jane G. Fischer RN Census bed type: Residential: 24 Total: 24 Census payor type: Other: 24 Total: 24 Sample: 4 Supplemental sample: 2 These State Residential findings are cited in accordance with 410 IAC 16.2-5.	R000000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted as a requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality Review was completed by Tammy Alley RN on July 7, 2014.			
R000036	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview the facility failed to ensure a concerned family member and the resident's physician was notified for possible intervention to alter medication treatment, in that when a resident had physician orders for a specific pain medication the nursing staff failed to inform the physician the resident did not receive the prescribed treatment for 1 of 4 sampled residents. (Resident "B") Findings include: The record for Resident "B" was reviewed on 07-02-14 at 1:10 p.m. Diagnoses included, but were not limited to, acute encephalopathy with severe	R000036	1.Resident B was not harmed. The order for Butrans patch had been clarified upon physician notification and the responsible party was notified. 2.All residents utilizing pain medications have the potential to be affected. All medication carts were checked with the medication administration records to ensure all ordered medications were present. All nurses and QMA's were re-educated on the facility's policy on Notification of Changes. 3.As a measure for ongoing compliance the DON or designee will review the 24 report sheet daily on regularly scheduled days of work ongoing to monitor for any changes in condition and proper documentation of physician and responsible party	07/16/2014

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	agitation, low back pain radiating down both legs, and hypertension. These diagnoses remained current at the time of the record review. The resident had original physician orders, dated 01-27-13 for Butrans (a transdermal medication patch for pain) 10 mcg/hr (micrograms per hour) - apply 1 patch topically and change every week on Sunday. A review of the Medication Administration Record for September 2013 indicated the resident had the transdermal patch applied on 09-01-13. Further review of the Medication Administration Record indicated the medication was "not available" for the resident on 09-08-13 or 09-15-14. During an interview on 07-02-14 at 12:00 p.m., a concerned family member indicated "We took [resident] to the pain clinic because he continued to have pain. I believe it was around the middle of September [2013] and at first we thought the pain medication needed to be increased. The doctor increased the patch to a 5 mcg patch and a 10 mcg patch to be put on at the same time, once a week. Originally the staff told me the patch was not in the cabinet, but we knew it had been delivered. I spoke with the		notification, (seeattachment A). 4.As a measure of quality assurance the DON will complete the above described monitoring ongoing. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator will monitor and sign off on the monitoring tools on a monthly basis ongoing. 5.The above corrective action will be completed on or before July 16, 2014.	

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	Regional Administrator and after she investigated it, is when we found out that the original patch was there and had not been applied as ordered." A review of the resident's record lacked documentation the physician or the family members were notified of the situation with the "unavailability" of the transdermal pain medication. A review of the facility policy on 07-03-14 at 11:00 a.m., titled "NOTIFICATION OF CHANGES," and dated 12-03 (2003) indicated the following: "POLICY: This facility shall 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: (3) a need to alter treatment due to adverse consequences or to commence a new form of treatment; ...." "PROCEDURE: 1.) All notification shall be made per telephone, via fax, or in person and recorded in the resident medical record." This State finding relates to Complaint IN00148969.			

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R000148	410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation and interview, the facility failed to ensure the building in good repair and free from potential hazards, in that when the residents and family members alerted the facility staff in regard to plumbing problems, the facility failed to act immediately to remedy the situation, and allowed a resident to be exposed to a potential fall hazard for 2 of 5 rooms observed and 2 of 4 sampled and 1 of 2 supplemental sampled resident. (Residents "A", "B"	R000148	1.Residents A, B, and E were not harmed. The plumbing problems have been repaired. 2.All residents residing in the facility have the potential to be affected. The maintenance man completed rounds throughout the entire facility to monitor for any further plumbing problems with none noted. 3.As a measure of ongoing compliance the maintenance man or designee will complete rounds throughout the facility monitoring	07/16/2014

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	and "E"). Findings include: During an interview on 07-02-14 at 12:02 p.m., a concerned family member indicated the floor to her parents room, was frequently observed with water on the floor. "There was flooding in the room and I was just appalled. The water seemed like it was coming from the room next door. I was told the person who lived next door let the shower run too long and the shower was overflowing. My parents carpet was wet, as well as the bathroom floor. The water, from the wall and outward measured 2 1/2 to 3 feet. My parents had to keep putting towels down to mop up the water. The staff told me they would have to bring in someone with a vacuum, to dry everything out. It happened two times the week we moved my parents out of the facility. They had me moved some of my parents belongings in the hallway. It didn't happen only once either. It occurred periodically since the fall of last year [2013]. I asked them to call the property manager, but they told me he couldn't do anything. Eventually I spoke with the Executive Director." During an interview on 07-02-14 at 12:10 p.m., the housekeeper verified the		for leaks and/or other plumbing issues weekly for four weeks, then every two weeks for four weeks, then monthly ongoing, (see attachment B). Additionally, staff have been advised of the completion of maintenance requisitions for known, observed or resident/family reported concerns in an effort to communicate the same to the Administrator and maintenance department. 4.As a measure of quality assurance the maintenance man or designee will complete the above described monitoring ongoing. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administratorwill monitor and sign off on the monitoring tools on a monthly basis ongoing. 5.The above corrective action will be completed on or before July 16, 2014.	

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	problems with the plumbing in the room adjacent to the room the concerned family member spoke of. In addition, the housekeeper indicated there was another room with plumbing problems. "With the water, and putting down the towels, it's just not clean." With permission of Resident "E," the bathroom shower area the shower head was leaking a steady stream of water and two towels had been placed adjacent to the drain. The bathroom flooring was wet between the shower and the commode. During this observation, the resident indicated "the shower head has been like this for about 3 weeks. The water keeps splashing out onto the floor. The maintenance man looked at it but he didn't know what to do." During an interview on 07-02-14 at 12:30 p.m., the maintenance man indicated there was a problem with the shower and the drainage the concerned family member spoke of and verified the concerns of Resident "E" and the shower head leaking. "I'm waiting for someone from corporate to come and help me with it. Yes it's been going on for about 3 weeks." During the daily Exit conference on 07-02-14 at 3:30 p.m., the Executive Director verified the extent of the			

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	plumbing problems, as noted by the concerned family member and indicated the repair involved tearing out part of the wall in order to remedy the plumbing situation. In addition the Executive Director acknowledged the problems with the plumbing in Resident "E" shower, and indicated he was unsure if the water had to be completely turned off to repair the leak. This State finding relates to Complaint IN00148969.			
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview the facility failed to ensure the physician orders were followed, and residents without medication errors, in that when residents had specific physician orders for medication administration, the nursing staff failed to ensure the residents received the medications as ordered by the physician for 3 of 4 sampled residents (Residents "A", "B" and "D").	R000241	1.Residents A, B, and D were not harmed. Staff involved were re-educated on the facility's Medication Administration policy. 2.All residents requiring medications to be administered by staff have the potential to be affected. All nurses and QMA's were re-educated on the facility's policy on Medication Administration. The DON or designee has completed medication administration	07/16/2014

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	Findings include: 1. The record for Resident "A" was reviewed on 07-02-14 at 10:10 a.m. Diagnoses included, but were not limited to, insulin dependent diabetes mellitus, neuropathy and arthritis. These diagnoses remained current at the time of the record review. The record indicated the Resident had physician orders dated 12-17-12 for Lantus 100 units/ml (milliliters) 64 units sub-Q (subcutaneous) every day. The record indicated the resident was transferred to a local area hospital on 03-05-13 and returned to the facility on 03-08-13. The return orders instructed the nurse to ensure the resident received Lantus insulin 20 units daily sub-Q upon return to the facility. A review of the Medication Administration Record for March 2013 indicated the resident received Lantus 64 units on March 9, 10, 11, 12 and 13 at 8:00 a.m. instead of the prescribed 20 units. A review of the Accuchecks for March 2013 indicated the resident's 8:00 a.m.		observations on all nurses and QMA's with satisfactory performance noted. 3.As a measure for ongoing compliance the DON or designee will complete medication administration observations, (see attachment C) weekly for four weeks, then every two weeks for four weeks, then monthly ongoing. Additionally all new medication orders will be checked by two staff members to monitor for correct transcription. 4.As a measure of quality assurance the DON will complete the above described monitoring ongoing. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator will monitor and sign off on the monitoring tools on a monthly basis ongoing. 5.The above corrective action will be completed on or beforeJuly 16, 2014.	

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	Accuchecks were as follows: 120 on March 9, 2014, 98 on March 10, 2014, 56 on March 11, 2014, 72 on March 12, 2014, 40 on March 13, 2014, 56 on March 14, 2014. A review of the Interdisciplinary Progress Notes, dated 07-03-14, as a "late entry" for 03-13-13 indicated the following: "I [myself] notified DON [Director of Nurses] that resident had fallen and was confused. DON went around to check on resident and noticed blood sugar was low. DON notified [physician name], notified family, also [family member] was visiting. Resident was confused so DON decided to send resident out 911 also per family request. Resident was sent to hospital 911." 2. The record for Resident "B" was reviewed on 07-02-14 at 1:10 p.m. Diagnoses included, but were not limited to, acute encephalopathy with severe agitation, low back pain radiating down both legs, and hypertension. These diagnoses remained current at the time of the record review. The resident had original physician orders, dated 01-27-13 for Butrans (a			

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	transdermal medication patch for pain) 10 mcg/hr (micrograms per hour) - apply 1 patch topically and change every week on Sunday. A review of the Medication Administration Record for September 2013 indicated the resident had the transdermal patch applied on 09-01-13. Further review of the Medication Administration Record indicated the medication was "not available" for the resident on 09-08-13 or 09-15-14. During an interview on 07-02-14 at 12:00 p.m., a concerned family member indicated "We took [resident] to the pain clinic because he continued to have pain. I believe it was around the middle of September [2013] and at first we thought the pain medication needed to be increased. The doctor increased the patch to a 5 mcg patch and a 10 mcg patch to be put on at the same time, once a week. Originally the staff told me the patch was not in the cabinet, but we knew it had been delivered. I spoke with the Regional Administrator and after she investigated it, is when we found out that the original patch was there and had not been applied as ordered." A review of the resident's record indicated the resident had a change in the			

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	dosage of the pain transdermal patch on 03-27-14. The physician order instructed the nurse to apply a 5 mcg/hr patch. This physician order was dated 03-27-14 and instructed the nurse "Replaces Butrans 15 mcg/hr patch." A review of the Controlled Record indicated "Butran 15 mcg/hr - apply 1 patch weekly for pain, rotating sites. The record indicated on 03-30-14 at 8:00 a.m., the 15 mcg/hr patch had been applied to the resident. A review of the Medication Record for March 2014 indicated the resident also received the 5 mcg/hr patch on 03-30-14. Further interview on 07-02-14 at 12:00 p.m., a concerned family member indicated when the resident arrived at "the new facility," [resident] had on two pain patches. One was for 5 mcg/hr and the other was for 15 mcg/hr and were "dated 03-30-14." 3. The record for Resident "D" was reviewed on 07-02-14 at 2:30 p.m. Diagnoses included, but were not limited, to diabetes mellitus, neuropathy, hypertension, depression and renal disorder. These diagnoses remained current at the time of the record review.			

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	Review of the resident's record indicated the resident had specific physician orders for medications to be administered at 8:00 p.m. During an interview on 07-03-14 at 10:00 a.m., the Director of Nurses verified the resident did not receive the scheduled medications as ordered. The Director of Nurses indicated the medications included Atorvastatin 10 mg (a medication for cholesterol), Levetiracetam 500 mg (a medications for seizures), and Lyrica 50 mg (a medication for neuropathy), until 1 1/2 hours after the scheduled time. "All of the oral 8:00 p.m. medications were given at 9:30 p.m." 4. A review of the facility policy on 07-03-14 at 11:00 a.m., titled "Medication Administration Policy and Procedure," and dated 09-05 (2005), indicated the following: "PURPOSE: To administer medications according to the guidelines set forth by the State and Federal regulations." "PROCEDURE: 1. Medications will be administered within 60 minutes before and/or after the time ordered." This State finding relates to Complaint			

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	IN00148969.			
R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview the facility failed to ensure physician orders were followed, in that when a resident had specific physician orders for medication, the nursing staff failed to notify the resident's physician the medication was not available and the need for possible physician intervention for additional orders for 1 of 4 sampled residents. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 07-02-14 at 1:10 p.m. Diagnoses included, but were not limited to, acute encephalopathy with severe agitation, low back pain radiating down both legs, and hypertension. These diagnoses remained current at the time of the record review. The resident had original physician orders, dated 01-27-13 for Butrans (a	R000247	1.Resident B was not harmed. The order for Butrans patch had been clarified upon physician notification and the responsible party was notified. 2.All residents utilizing pain medications have the potential to be affected. All medication carts were checked with the medication administration records to ensure all ordered medications were present in the cart. All nurses and QMA's were re-educated on the facility's policy on Notification of Changes. 3.As a measure for ongoing compliance the DON or designee will review the 24 report sheet daily onregularly scheduled days ongoing to monitor for any changes in condition and/or medication issues and proper documentation of physician and responsible party notification, (see attachment A). 4.As a measure of quality assurance the DON will complete the above described monitoring ongoing. Should a deficient practice be observed, immediate	07/16/2014

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	transdermal medication patch for pain) 10 mcg/hr (micrograms per hour) - apply 1 patch topically and change every week on Sunday. A review of the Medication Administration Record for September 2013 indicated the resident had the transdermal patch applied on 09-01-13. Further review of the Medication Administration Record indicated the medication was "not available" for the resident on 09-08-13 or 09-15-14. During an interview on 07-02-14 at 12:00 p.m., a concerned family member indicated "We took [resident] to the pain clinic because he continued to have pain. I believe it was around the middle of September [2013] and at first we thought the pain medication needed to be increased. The doctor increased the patch to a 5 mcg patch and a 10 mcg patch to be put on at the same time, once a week. Originally the staff told me the patch was not in the cabinet, but we knew it had been delivered. I spoke with the Regional Administrator and after she investigated it, is when we found out that the original patch was there and had not been applied as ordered." A review of the resident's record lacked documentation the physician was notified		corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator will monitor and sign off on the monitoring tools on a monthly basis ongoing. 5.The above corrective action will be completed on or before July 16, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	of the situation with the "unavailability" of the transdermal pain medication. A review of the facility policy on 07-03-14 at 11:00 a.m., titled "NOTIFICATION OF CHANGES," and dated 12-03 (2003) indicated the following: "POLICY: This facility shall 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: (3) a need to alter treatment due to adverse consequences or to commence a new form of treatment; ...." This State finding relates to Complaint IN00148969.			
R000301	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription.			

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	If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on on observation, interview and record review the facility failed to ensure the appropriate labeling of prescription medications for 1 of 4 sample and 1 of 2 supplemental sampled residents reviewed during a medication administration observation. (Residents "C" and "F"). Findings include: 1. The record for Resident "C" was reviewed on 07-02-14 at 9:10 a.m. Diagnoses included, but were not limited to, diabetes, cerebral vascular accident, coronary artery disease, congestive heart failure and acute renal failure. These diagnoses remained current at the time of the record review. The record indicated the resident had a hospitalization in February 2014. Upon discharge from the hospital the "Discharge Instructions," included HumaLOG insulin to be administered if needed for sliding scale insulin coverage for specific blood sugar ranges. A review of the physician re-writes for the months of January 2014, February 2014 and March 2014, instructed the nursing staff to the use of HumaLOG	R000301	1.Resident C and F were not harmed. Resident C's orders were clarified. A "direction change"label was added to resident F's Ropinirole medication label immediately upon noting the discrepancy. 2.All residents requiring medication have the potential to be affected. All medication labels were compared to the medication administration records to ensure the labels were accurate, "direction change"labels applied as warranted. 3.As a measure for ongoing compliance the DON or designee will complete medication administration observations, (see attachment C) weekly for four weeks, then every two weeks for four weeks, then monthly ongoing. 4.As a measure of quality assurance the DON will complete the above described monitoring ongoing. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator or Regional Director will monitor and sign off on the monitoring tools on a monthly basis ongoing. 5.The above corrective action will be completed on or beforeJuly 16, 2014	07/16/2014

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	insulin. However the April 2014 and May 2014 physician re-writes instructed the nursing staff to use NovoLOG insulin. During the daily Exit conference on 07-02-14 at 3: 30 p.m. the Director of Nurses indicated the "resident had never been on HumaLOG insulin, only NovoLOG insulin." The resident's record lacked a physician order or clarification of the type of insulin the resident should receive. During an interview on 07-03-14 at 10:05 a.m., the Director of Nurses verified she spoke with the nurse practitioner who indicated she wanted the resident to remain on NovoLOG insulin. The Director of Nurses further indicated a clarification order had not been written per the direction of the nurse practitioner until 07-03-14. 2. During observation of a medication administration on 07-02-14 at 8:15 a.m., The QMA (Qualified Medication Aide) prepared the medications for Resident "F." The medications included Ropinirole (a medication for Parkinson's disease). The			

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	label on the bottle instructed the staff to administer "2 - 1 milligram tablets to the resident two times a day." A review of the Medication Administration Record for July 2014 the physician order dated 06-01-14, "Ropinirole HCL 2 mg table <sic> 1 tablet by mouth two times a day." During the reconciliation of the resident drug regime indicated the specific physician order dated 06-01-14 indicated Ropinirole HCL 2 mg table <sic> 1 tablet by mouth two times a day. During an interview on 07-03-14 at 9:00 a.m., the corporate nurse consultant verified the labeling needed to be corrected. A review of the facility policy on 07-03-14 at 11:00 a.m., titled "Medication Administration Policy and Procedure," and dated 09-05 (2005), indicated the following: "Purpose: To Administer medications according to the guidelines set forth by the State and Federal regulations." "Procedure: 2.) Medications will be checked 3 times to verify order with label during set up."			

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	The nursing staff failed to ensure correct labeling of the medication. This State finding relates to Complaint IN00148969.			