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	03/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SENIOR SUITES AT THE LELAND, LLC	900 SOUTH A STREET RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00287960. Complaint IN00287960 - Substantiated. State Residential Finding related to the allegations are cited at R0241, R0247, R0301 and R0349. Survey dates: March 11, 12 and 13, 2019 Facility number: 012497 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 22, 2019	R 0000		
R 0241 Bldg. 00	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 observation, interview and record review, the facility failed to ensure a resident did not receive a peer's medication in error, residents received medications as ordered by the physician, a resident received a calcium supplement as ordered by the physician and a resident did not have his medication thrown away for 4 of 11 residents reviewed for accurate receipt of medications. (Residents B, G, H and M)	R 0241	**Preparation and implementation of this Plan of Correction does not constitute admission or agreement by Community with the facts, findings, or other statements as alleged in the survey findings dated March 11 thru 13, 2019.**	03/29/2019

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

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	Findings include: 1. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated Resident H was given incorrect medications. The Corporate Nurse supplied copies of an "Employee Incident Report," dated 2-10-19, indicating on this date, "nurse accidentally gave a resident another resident's medication." The nursing notes of LPN 5, indicated on 2-10-19 at 7:40 p.m., she had administered the medications for another resident in error. It indicated upon realizing the error, approximately 20 minutes later, vital signs were obtained, the attending physician and the resident's daughter and the facility's supervisor were notified. Orders were received from the attending physician to monitor the resident and her vital signs and to notify the attending physician for any change in condition. No change in condition was denoted beyond feeling dizzy the following day. The medications given in error were identified as calcium 600 mg plus vitamin D-3 400 units, ferrous sulfate 325 milligrams (mg), isosorbide 10 mg, lisinopril 10 mg, metoprolol 25 mg, potassium chloride 20 millequivalents and simvastatin 20 mg. Resident H's clinical record was reviewed on 3-12-19 at 10:50 a.m. Her diagnoses included, but were not limited to hypertension, anxiety, depression, congestive heart failure and pain. 2. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated in January of 2019, the facility provided "write ups" to several employees related to not giving Resident B an ordered antibiotic, but documenting the medication had been administered. She indicated		**Submission of the Plan of Correction is required by law and does not evidence the truth of any of the findings. Community specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.** **Based on observation, interview and record review, the facility failed to ensure a resident did not receive a peer's medication in error, residents received medications as ordered by the physician, a resident received a calcium supplement as ordered by the physician and a resident did not have his medication thrown away for 4 of 11 residents reviewed for accurate receipt of medications. (Residents B, G, H and M)** Statement not clear, it states that resident received medications as ordered by physician, resident did not have medications thrown away for 4 of 11 residents reviewed. Does this mean 7 residents had their medications thrown away and only 4 didn't? Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated in January of 2019, the facility provided "write ups" to several	

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	near the end of the course of the medication, she observed several pills remaining in the bottle. She indicated the antibiotic ordered was Amoxicillin 1 gram every eight hours for five days for an upper respiratory infection, with an order and start date of 1-15-19. The antibiotic was to be completed on 1-20-19, but on 1-22-19, an unspecified number of the medication remained in the medication cart and several employees had signed off on the medication administration record as having administered the medication, but did not actually do so. An "Employee Coaching" form for LPN 3 and LPN 4 related to signing off the medication without actually administering the medication for Resident B was signed by each LPN without any comment. The Corporate Nurse also identified additional concerns with the antibiotic order in which the Amoxicillin had been entered into the computerized medical record for the medication to be given three times daily, not every eight hours by LPN 7 on 1-15-19. The "Employee Coaching" form, signed 1-28-19, indicated, "This changed the integrity of the order." The Corporate Nurse indicated LPN 7 had entered other orders on 1-15-19, for Resident B from the Nurse Practitioner (NP) on 1-15-19, incorrectly into the computer system as follows: -The NP order indicated Prednisone 10 mg [milligrams] twice daily for five days. The order was entered into the computerized medical system to be given for only three days, not five days. -The NP order indicated Mucinex DM to be given according to the package directions. This order was not located in the computerized medical system.		employees related to not giving Resident B an ordered antibiotic, but documenting the medication had been administered. **She indicated during the investigation of this infraction after the of the course of the medication, she observed several of the ordered 15 tablets of the antibiotic still in the bottle.** Corporate nurse never indicated seeing pills. Upon investigations the pills were no longer in the cart as time for administration had passed. **In an interview with the Administrator on 3-11-19 at 12:30 p.m., she indicated the facility had a situation in which LPN 3 was observed on camera to throw away a resident's medication into the trash can.** Administrator didn't indicated this information to surveyor. This was discussed with Corporate Nurse **On 3-12-19 at 12:18 p.m., the Corporate Nurse provided a copy of an undated policy entitled, "Medication Administration and Documentation for Assisted Living Communities.** This policy wasn't given to the Surveyor by the Corporate but in	

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	Another antibiotic was ordered by her physician on 1-18-19, for continued upper respiratory infection. The resident's pharmacy received an emailed prescription for Zithromax 250 mg to take two tablets on day 1 and then one tablet daily for four days was received by the pharmacy on 1-18-19 at 1:53 p.m. A nursing note, dated 1-18-19 at 5:36 p.m., indicated Resident B had received a new order for "Z-pack" for an upper respiratory infection. A nursing note, dated 1-21-19 at 1:21 p.m., indicated "Started ATB [antibiotic] this morning. Resident with head congestion she reports." The associated medication administration record indicated the order was identified to begin the intial two pill dosage on 1-19-19, for a morning dose, but this was left blank, signifying it had not been administered. The remaining four one pill doses were identified to begin on the morning of 1-20-19 through 1-23-19. The documentation indicated LPN 3 administered the 1-20-19 dose, LPN 11 administered the 1-21-19 dose, LPN 7 administered the 1-22-19, dose and the 1-23-19 dose was left blank, signifying it had not been administered. Resident B's clinical record was reviewed on 3-11-19 at 12:15 p.m. Her diagnoses included, but were not limited to, cerebral infarction, TIA's (transient ischemic attacks, also known as mini-strokes) and hypertension. 3. During 1 of 2 medication pass observations with 3 staff, QMA 9 was observed to dispense six medications to Resident G on 3-11-19 at 10:42 a.m., including one vitamin supplement tablet of "Calcium, Magnesium and Zinc". The label identified the vitamin supplement contained calcium carbonate 1000 mg, magnesium oxide 400 mg and zinc 15 mg. Review of the physician's		fact given by the Administrator: Attached also find our plan of correction: <u>Deficiency R-241 POC</u> 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **a. After identifying the resident, the clinical staff contacted the MD for direction and family for notification of the incident. Furthermore, the clinical staff followed the order of the on-call practitioner and continued monitoring the resident for adverse signs and symptoms. The facility followed up with the resident's primary care physician the next day for any new orders and to give report of monitoring and at that time the residents current condition.** 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: a. **By use of both pictures for identification purposes and asking resident to state their full name the facility staff will successfully identify each resident prior to the administration of any medication**	

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	order, with a start date of 9-20-17, indicated he was to receive calcium carbonate 600 mg twice daily. Observation of the vitamin supplement bottle after the above dose was administered indicated 14 tablets remained of the labeled bottle of 100 were present. In an interview with QMA 9 on 3-11-19 at 10:42 a.m., she indicated the resident's family provides the vitamin supplement. The clinical record of Resident G was reviewed on 3-11-19 at 3:49 p.m. His diagnoses included, but were not limited to lymphoma, anemia and arthritis. 4. In an interview with the Administrator on 3-11-19 at 12:30 p.m., she indicated the facility had a situation in which LPN 3 was observed on camera to throw away a resident's medication into the trash can. Review of a "Employee Written Warning," form, dated 1-27-19, indicated, "Employee was observed discarding a resident's evening medications, [initials of Resident M]. Employee was observed taking the medications out of the medication cart and discarding it [into] the recycle bin. Medication was retrieved from the recycle bin still in packaging unopened. Employee [had] marked the medications as given." In an interview with the Corporate Nurse on 3-13-19 at 9:30 a.m., she indicated on 1-27-19, she and the Administrator had been observing the camera feeds for the facility. She indicated she observed LPN 3 to use a chair to roll over to the medication cart, get something out of the medication cart and then dispose of it into the recycle while saying, "He ain't coming down [to		3. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur; a. i. **All clinical nursing staff (LPN/QMA) have been in-service on using the 6 rights of medication to identify, but not limited to the right medication and the right resident every time. (completed 3/28 & 3/29/2019)** 1. **6 right of medication administration check for each staff LPN/QMA has been completed (attachment)** ii. **For proper identification purposes the electronic medical records system (Point Click Care – PCC) houses a picture of every facility admitted resident for easy identification of each resident, every picture is available on the electronic MAR and will be consulted prior to the administration of any medication.** iii. **All clinical staff has been re-in serviced on the policy/procedure and proper course of action to take if a medication error occurs. (completed 3/28 & 3/29/2019)**	

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	the clinic to receive his medications] and I ain't going up there [to his room to administer his medications]." She indicated she requested for the Administrator to re-wind the tape to review it for a second time, "to make sure what I saw and heard was correct and it was." She indicated she then went to the nurse's station and retrieved the medication pack from the recycle bin and found the package intact and unopened. She indicated LPN 3 had already documented she had administered the three medications of cyclobenzapr 5 mg, donepezil 10 mg and metoprolol tartrate 25 mg. She indicated she then ensured Resident M received his evening medications. Review of Resident M's clinical record was conducted on 3-13-19 at 9:50 a.m. His diagnoses included, but were not limited to dementia, hypertension and pain. On 3-12-19 at 12:18 p.m., the Corporate Nurse provided a copy of an undated policy entitled, "Medication Administration and Documentation for Assisted Living Communities." This policy indicated, It is the policy of this community to establish and maintain a safe and effective medication delivery system which supports the aging in place concept and promotes the availability of appropriate services for the senior population in a home like environment which enhances their dignity, independence, individuality, privacy, decision making abilities and choice of the resident. Our nursing staff will administer or assist the resident to administer prescription and non-prescription (OTC) medications as allowed per state and our pharmacy regulations and will maintain accurate records of medication administration...During Medication Administration, staff must observe		iv. **All clinical staff have been audited of their medication administration practices and have been trained to incorporate the 6 rights of medication administration into this practice. (completed 3/28 & 3/29/2019)** 4. How the corrective action(s) be monitored to ensure the deficient practice will not recur? **a. Both Semi-annually and upon hire all clinical staff will be retrained and/or trained (re-in serviced) on the newly in place medication identity and administration practices, including the 6 rights of medication.** **i. Randomly the DON will audit and document nursing staff medication administration to insure practices are being followed.** **Randomly the DON will audit and document nursing staff medication administration to insure practices are being followed, utilizing the following schedule:** **i. Every other week for 2 months;** **ii. then monthly for 4 months;** **iii. then quarterly for 6 months**	

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	the Resident to assure the medications have been administered...Proper documentation of any and all Medication administration can ONLY happen after the observation of the medication being ingested, swallowed, absorbed, injected or any other directed (ordered) means of ingestion..." This Residential tag relates to Complaint IN00287960. 2.5-4(e)		5. By what date the systemic changes will be completed? **a. Systemic changes have already been installed orientation and in services were completed on 3/28 & 3/29/2019.**	
R 0247 Bldg. 00	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 interview and record review, the facility failed to ensure errors in medication administration and physician notification of the errors were documented in residents' clinical records for 3 of 11 residents reviewed for accuracy of medication administration (Residents B, J and K). Findings include: 1. Resident B's clinical record was reviewed on 3-11-19 at 12:15 p.m. Her diagnoses included, but were not limited to, cerebral infarction, TIA's (transient ischemic attacks, also known as mini-strokes) and hypertension. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated in January of	R 0247	**Preparation and implementation of this Plan of Correction does not constitute admission or agreement by Community with the facts, findings, or other statements as alleged in the survey findings dated March 11 thru 13, 2019. Submission of the Plan of Correction is required by law and does not evidence the truth of any of the findings. Community specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.**	03/29/2019

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	2019, the facility provided "write ups" to several employees related to not giving Resident B an ordered antibiotic, but documenting the medication had been administered. She indicated near the end of the course of the medication, she observed several pills remaining in the bottle. She indicated the antibiotic ordered was Amoxicillin 1 gram every eight hours for five days for an upper respiratory infection, with an order and start date of 1-15-19. The antibiotic was to be completed on 1-20-19, but on 1-22-19, an unspecified number of the medication remained in the medication cart and several employees had signed off on the medication administration record as having administered the medication, but did not actually do so. An "Employee Coaching" form for LPN 3 and LPN 4 related to signing off the medication without actually administering the medication for Resident B was signed by each LPN without any comment. The Corporate Nurse also identified additional concerns with the antibiotic order in which the Amoxicillin had been entered into the computerized medical record for the medication to be given three times daily, not every eight hours by LPN 7 on 1-15-19. The "Employee Coaching" form, signed 1-28-19, indicated, "This changed the integrity of the order." The Corporate Nurse indicated LPN 7 had entered other orders on 1-15-19, for Resident B from the Nurse Practitioner (NP) on 1-15-19, incorrectly into the computer system as follows: -The NP order indicated Prednisone 10 mg [milligrams] twice daily for five days. The order was entered into the computerized medical system to be given for only three days, not five days.		**Based on interview and record review, the facility failed to ensure a resident identified with a medication error was monitored for negative effects related to the error, the resident's physican was notified immediately of the mediation error and the notification was documented in the resident's clinical record for 4 of 11 residents reviewed for accuracy of receipt of medications. (Resident B, H, J and K)** The facility did not fail to monitor this resident for negative effects related to this error. This resident was monitored and it was documented on the date of the error, this information was shown to the surveyor when in facility. Is this stating that there were 11 residents that had a medication errors? Documentation of how med error was conducted, copied from citation report: **The nursing notes of LPN 5, indicated on 2-10-19 at 7:40 p.m., she had administered the medications for another resident in error. It indicated upon realizing the error,**	

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	-The NP order indicated Mucinex DM to be given according to the package directions. This order was not located in the computerized medical system. Another antibiotic was ordered by her physician on 1-18-19, for continued upper respiratory infection. The resident's pharmacy received an emailed prescription for Zithromax 250 mg to take two tablets on day 1 and then one tablet daily for four days was received by the pharmacy on 1-18-19 at 1:53 p.m. A nursing note, dated 1-18-19 at 5:36 p.m., indicated Resident B had received a new order for "Z-pack" for an upper respiratory infection. A nursing note, dated 1-21-19 at 1:21 p.m., indicated "Started ATB [antibiotic] this morning. Resident with head congestion she reports." The associated medication administration record indicated the order was identified to begin the pintail two pill dosage on 1-19-19, for a morning dose, but this was left blank, signifying it had not been administered. The remaining four one pill doses were identified to begin on the morning of 1-20-19 through 1-23-19. The documentation indicated LPN 3 administered the 1-20-19 dose, LPN 11 administered the 1-21-19 dose, LPN 7 administered the 1-22-19, dose and the 1-23-19 dose was left blank, signifying it had not been administered. In an interview on 3-12-19, the Corporate Nurse indicated she could not locate any documentation to address Resident B's physician had been notified of the medications errors. Documentation in Resident B's clinical record failed to identify any of the above mentioned medication errors had been addressed in the record or with the physician.		**approximately 20 minutes later, vital signs were obtained, the attending physician and the resident's daughter and the facility's supervisor were notified. Orders were received from the attending physician to monitor the resident and her vital signs and to notify the attending physician for any change in condition. No change in condition was denoted beyond feeling dizzy the following day. The medications given in error were identified as calcium 600 mg plus vitamin D-3 400 units, ferrous sulfate 325 milligrams (mg), isosorbide 10 mg, lisinopril 10 mg, metoprolol 25 mg, potassium chloride 20 millequivalents and simvastatin 20 mg. Resident H's clinical record was reviewed on 3-12-19 at 10:50 a.m. Her diagnoses included, but were not limited to hypertension, anxiety, depression, congestive heart failure and pain.** **In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated in January of 2019, the facility provided "write ups" to several employees** This information was asked of the Administrator not the Corporate Nurse.	

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	2. The clinical record of Resident J was reviewed on 3-12-19 at 9:10 a.m. Her diagnoses included, but were not limited to polyarthritis and anxiety. Her active orders, effective as of 1-7-19 included, but were not limited to, Percocet 10/325 mg three times daily as needed for pain. The EMAR for 1-7-19, indicated Resident J received this medication one time at 11:57 a.m. from LPN 11. Her "Controlled Medication Count Sheet," for Percocet 10/325 mg indicated she had received this medication on 1-7-19 at 12:00 p.m., by LPN 11 and at 8:30 p.m. by LPN 7. It also indicated on 1-7-19, with no time listed, as having two tablets of this medication listed as "wasted" by LPN 4. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated, "I'm still not sure I understand the exact details but [name of LPN 4] had signed out as 'wasted' two Percocet 10/325 milligrams [mg] on [name of Resident J]. But [LPN 4] also marked out two doses of Norco 10/325 mg that [name of LPN 11] had given to [name of Resident K], all on 1-7-19. The issue was she [LPN 4] was not upfront with the Administrator about the count being off and trying to fix it, falsify, the error." The Corporate Nurse indicated a narcotic that is "wasted" or disposed of requires two nurses in order to complete the task and to have another licensed nurse to observe this and both nurses are to sign off on the narcotic record and this did not occur. An "Employee Discipline Report," form, dated 1-10-19, indicated on 1-7-19, LPN 4 did not communicate a medication error with the Administrator and falsified records "to cover up the error." Documentation in Resident J's clinical record failed to identify any of the above mentioned medication errors had been addressed in the		**She indicated during the investigation of this infraction after the of the course of the medication, she observed several of the ordered 15 tablets of the antibiotic still in the bottle.** The Corporate Nurse did not indicate observing tablets. Deficiency R -247 POC 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **a. When residents present with any special concerns, new orders or any other incidental will be included on 24-hour reports sheet to communicate to nurses on every shift these incidental concerns for proper monitoring.** 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: **a. All residents identified with special concerns, new orders, return from hospital or doctor's visits or any other wellness center incidentals will be included on 24-hour reports sheet to communicate to nurses on every shift incidental concern for proper monitoring.**	

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	record or with the physician. 3. The clinical record of Resident K was reviewed on 3:00 p.m. Her diagnoses included, but were not limited to unspecified pain and anxiety. Her active orders, effective as of 1-7-19 included, but were not limited to, Norco 10/325 mg every 4-6 hours as needed for pain. The EMAR for 1-7-19, indicated Resident K received this medication two times, at 6:40 a.m. and at 11:25 a.m., from LPN 11. Her "Controlled Medication Count Sheet," for Norco 10/325 mg indicated she received this medication on 1-7-19 at 6:45 a.m., from LPN 11, at 11:30 a.m., from LPN 11, at 3:00 p.m., from LPN 4 and at 6:30 p.m. from LPN 4. This form had a line marked through the entries for 1-7-19, at 6:45 a.m. and at 11:30 a.m. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated, "I'm still not sure I understand the exact details but [name of LPN 4] had signed out as 'wasted' two Percocet 10/325 milligrams [mg] on [name of Resident J]. But [LPN 4] also marked out two doses of Norco 10/325 mg that [name of LPN 11] had given to [name of Resident K], all on 1-7-19. The issue was she [LPN 4] was not upfront with the Administrator about the count being off and trying to fix it, falsify, the error." The Corporate Nurse indicated a narcotic that is "wasted" or disposed of requires two nurses in order to complete the task and to have another licensed nurse to observe this and both nurses are to sign off on the narcotic record and this did not occur. An "Employee Discipline Report," form, dated 1-10-19, indicated on 1-7-19, LPN 4 did not communicate a medication error with the Administrator and falsified records "to cover up the error."		3. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur? **a. All clinical nursing staff have been in serviced on the correct way to document medication errors, who to notify and how to properly chart all information in the resident's electronic medical record. (completed 3/28 & 3/29/2019)** **b. All medication orders will be verified by 2 nurses and signed off in a nursing note.** **c. Any and all residents identified on anti-biotic therapy or identified on the 24-hour report sheet will have orders reviewed by DON or her designee every morning.** **i. Antibiotics will be counted like narcotics at the beginning and end of every shift by every nurse.** **ii. Antibiotic count will be signed off on Antibiotic count sheet every shift (see attachment)** **d. All residents identified with special concerns, new orders or any other incidental will be included on 24-hour reports sheet to communicate to nurses on every shift these**	

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	Documentation in Resident K's clinical record failed to identify any of the above mentioned medication errors had been addressed in the record or with the physician. On 3-12-19 at 1:55 p.m., the Corporate Nurse provided a copy of a policy entitled, "Medication Error Policy and Procedures," with an approval date of 11-1-17. This policy indicated, " Medication error means a discrepancy between what the physician ordered and what was not administered. Medication errors are to be brought to the prompt attention of the Director of Nursing or Nurse Manager. Contact the attending physician immediately of any adverse reactions. All medication errors must be brought to the attention of the Regional Nursing Director. Medication Errors require that the following course of action be followed: Immediately note the time and obtain a full set of Vital Signs; call/page attending physician for direction and orders; Contact and inform DON/Nurse manager; If necessary, call EMT; If alert, explain the incident to the resident; Contact family or other responsible party; Call hospital and give a full detailed report of incident; Chart in detail in the resident's medical record; Identify everyone notified and time..." This Residential tag relates to Complaint IN00287960. 2.5-4(e)(7)		**incidental concerns for proper monitoring, follow up and endorsement.** **e. For proper identification purposes the electronic medical records system (Point Click Care – PCC) houses a picture of every facility admitted resident for easy identification of each resident, every picture is available on the electronic MAR and will be consulted prior to the administration of any medication.** **f. By use of both pictures for identification purposes and asking resident to state their full name the facility staff will successfully identify each resident prior to the administration of any medication** **g. All narcotics according to facility policy will continue to be counted q shift, if there is a miscount or any concerns will be brought to the attention of the Director of Nursing immediately, all narcotics will be disposed of according to pharmacy policy and procedure for the disposal or destruction of controlled medications.** **i. All staff will be in serviced on the pharmacy policy and procedure for the disposal of controlled**	

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			medications. **ii. All staff have been re-trained on signing off narcotics on the narcotic administration record.** **iii. Rx destroyer (purchased) will be utilized for the destruction of controlled medications.** **iv. All disposed of medications will be documented in the resident's electronic medical record and will include: the name and strength of drug, Rx #, reason for disposal, method of disposal, amount being disposed, date of disposal and signature of both persons disposing and any witnesses.** 4. How the corrective action(s) be monitored to ensure the deficient practice will not recur? **a. Semi Annually and randomly the DON will audit all nursing staff to insure practices are being followed and will retrain staff accordingly if necessary.** **b. DON or her designee will review the wasted or discontinued medication sign off sheet** **c. Controlled medication binder will be maintained and**	

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			reviewed by DON weekly **d. DON or designee will review Antibiotic count sheets (attachment)** **i. Daily for 30 days** **ii. Every other day for 30 days** **iii. Weekly for 6 weeks** **iv. Randomly thereafter** 5. By what date the systemic changes will be completed? **a. 3/28 & 3/29/2019**	
R 0301 Bldg. 00	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. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are			

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	permitted. Based on observation, interview and record review, the facility failed to ensure an insulin pen had appropriate labeling in place for 1 of 5 residents observed during a medication pass observation. (Resident N) Findings include: During 1 of 2 medication pass observations with 3 staff and 5 residents on 3-11-19 at 11:02 a.m., LPN 10 was observed to obtain a Humalog KwikPen for Resident N. Handwritten on the pen was the Resident's last name, the date it was put into use, as well as the manufacturer's label which included the name of the medication, strength of the medication and it's expiration date. The pen did not have the following information present: -resident's full name. -name of the ordering physician. -prescription number. -directions for use. -name and address of the pharmacy that filled the prescription. -date when pen will expire, based upon the date it was put into use. In interview with LPN 10 at this time, she indicated she was new to the facility and was not familiar with what was supposed to be on the label. She indicated she had located the correct insulin pen for Resident N and followed the orders/directions located in the medication administration record. The clinical record of Resident N was reviewed on 3-12-19 at 4:15 p.m. Her diagnoses included, but were not limited to diabetes. An order summary, dated 3-13-19, indicated her Humalog insulin orders were as follows: -Humalog insulin KwikPen 10 units three times	R 0301	**Preparation and implementation of this Plan of Correction does not constitute admission or agreement by Community with the facts, findings, or other statements as alleged in the survey findings dated March 11 thru 13, 2019. Submission of the Plan of Correction is required by law and does not evidence the truth of any of the findings. Community specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.** Deficiency R-301 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? **a.** All Insulin pens that come from other pharmacies that did not have the proper labeling have been labeled to reflect the name of resident, and directions of use 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: **a.** All Insulin pens that come from other pharmacies that did not have the proper labeling have been	03/29/2019

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	daily injected subcutaneously (SQ), with an order date of 5-15-18. -Humalog insulin KwikPen to receive a sliding scale dose of insulin four times daily SQ based on her blood glucose results. The sliding scale indicated for blood glucose results of 0-150, give 0 units; 151-200, give 4 units; for 201-250, give 8 units; for 251-300, give 12 units; for 301-350, give 16 units; for 351-399, give 20 units; for 400 to 599, give 20 units and call the physician. This order went into effect 5-7-18. In interview on 3-13-19 at 12:10 p.m., with the Corporate Nurse, she indicated the facility does not have any specific policies regarding medication labeling. This Residential tag relates to Complaint IN00287960. 2.5-6(c)(5)(A) 2.5-6(c)(5)(B) 2.5-6(c)(5)(C) 2.5-6(c)(5)(E) 2.5-6(c)(5)(F) 2.5-6(c)(5)(G)		labeled to reflect the name of resident, and directions of use 3. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur? **a. All outside pharmacies <u>are being contacted</u> to ensure that all insulin pens and vials come properly labeled according to state regulations and policy.** **(Ongoing)** **b. Unit secretary or designee will make labels for insulin pens or vials that come from pharmacies without labeling on the insulin pens or vials. Labeling will include: Resident name, Rx #, directions for use, area for indication of open date, expiration date.** **i. DON or designee will insure that labeling directions are accurate and clear.** **c. Clinical nursing staff have been in serviced on the need for correct labeling on each insulin pen and vial.** 4. How the corrective action(s) be monitored to ensure the deficient practice will not recur? **a. DON or designee will monitor that labels remain on insulin pens and vials**	

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			5. By what date the systemic changes will be completed? **a. 3/28 & 3/29/2019**	
R 0349 Bldg. 00	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. Based on interview and record review, the facility failed to ensure documentation related to each resident is present and correct for 4 of 11 residents reviewed for accurate medication receipt. (Resident B, C, J and K) Findings include: 1. Resident B's clinical record was reviewed on 3-11-19 at 12:15 p.m. Her diagnoses included, but were not limited to, cerebral infarction, TIA's (transient ischemic attacks, also known as mini-strokes) and hypertension. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated in January of 2019, the facility provided "write ups" to several employees related to not giving Resident B an ordered antibiotic, but documenting the medication had been administered. She indicated during the investigation of this infraction after the of the course of the medication, she observed	R 0349	**Preparation and implementation of this Plan of Correction does not constitute admission or agreement by Community with the facts, findings, or other statements as alleged in the survey findings dated March 11 thru 13, 2019. Submission of the Plan of Correction is required by law and does not evidence the truth of any of the findings. Community specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.** Deficiency R-349 1. What corrective action(s)	03/29/2019

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	several of the ordered 15 tablets of the antibiotic still in the bottle. She indicated the antibiotic ordered was Amoxicillin 1 gram every eight hours for five days for an upper respiratory infection, with an order and start date of 1-15-19. The antibiotic was to be completed on 1-20-19, but on 1-22-19, an unspecified number of the medication remained in the medication cart and several employees had signed off on the medication administration record as having administered the medication, but did not actually do so. An "Employee Coaching" form for LPN 3 and LPN 4 related to signing off the medication without actually administering the medication for Resident B was signed by each LPN without any comment. The Corporate Nurse also identified additional concerns with the antibiotic order in which the Amoxicillin had been entered into the computerized medical record for the medication to be given three times daily, not every eight hours by LPN 7 on 1-15-19. The "Employee Coaching" form, signed 1-28-19, indicated, "This changed the integrity of the order." The Corporate Nurse indicated LPN 7 had entered other orders on 1-15-19, for Resident B from the Nurse Practitioner (NP) on 1-15-19, incorrectly into the computer system as follows: -The NP order indicated Prednisone 10 mg [milligrams] twice daily for five days. The order was entered into the computerized medical system to be given for only three days, not five days. -The NP order indicated Mucinex DM to be given according to the package directions. This order was not located in the computerized medical system.		will be accomplished for those residents found to have been affected by the deficient practice? **a. All resident records will be maintained to reflect accurate documentation so that all incidents and correspondence is reflected in the resident's electronic medical record.** 2. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: **a. All resident records will be maintained to reflect accurate documentation so that all incidents and correspondence is reflected in the resident's electronic medical record.** 3. What measures will be put in place or what systemic changes will the facility make to ensure that the deficient practice does not recur? **a. All clinical nursing staff (LPN/QMA) have been in-service on using the 6 rights of medication to identify, but not limited to the right medication and the right resident every time. (completed 3/28 & 3/29/2019)** i. **6 right of medication administration**	

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	Another antibiotic was ordered by Resident B's physician on 1-18-19, for continued upper respiratory infection. The resident's pharmacy received an emailed prescription for Zithromax 250 mg to take two tablets on day 1 and then one tablet daily for four days was received by the pharmacy on 1-18-19 at 1:53 p.m. A nursing note, dated 1-18-19 at 5:36 p.m., indicated Resident B had received a new order for "Z-pack" for an upper respiratory infection. A nursing note, dated 1-21-19 at 1:21 p.m., indicated "Started ATB [antibiotic] this morning. Resident with head congestion she reports." The associated medication administration record indicated the order was identified to begin the initial two pill dosage on 1-19-19, for a morning dose, but this was left blank, signifying it had not been administered. The remaining four one pill doses were identified to begin on the morning of 1-20-19 through 1-23-19. The documentation indicated LPN 3 administered the 1-20-19 dose, LPN 11 administered the 1-21-19 dose, LPN 7 administered the 1-22-19, dose and the 1-23-19 dose was left blank, signifying it had not been administered. In an interview on 3-12-19, the Corporate Nurse indicated she could not locate any documentation to address Resident B's physician, Director of Nursing, Administrator or the families had been notified of the medications errors. Documentation in Resident B's clinical record failed to identify any of the above mentioned medication errors had been addressed. 2. The clinical record of Resident C was reviewed on 3-11-19 at 2:10 p.m. His diagnoses included, but were not limited to hypertension, bronchitis, anxiety, depression and history of urinary tract infection.		**check for each staff LPN/QMA has been completed (attachment)** **b. All clinical staff have been in serviced /retrained on the importance of proper documentation practices, the importance of proper notification, follow up, reporting and endorsements.** **c. Any and all residents identified on anti-biotic therapy or identified on the 24-hour report sheet will have orders reviewed by DON or her designee every morning.** **i. Antibiotics will be counted like narcotics at the beginning and end of every shift by every nurse.** ii. **Antibiotic count will be signed off on Antibiotic count sheet every shift (see attachment)** 4. How the corrective action(s) be monitored to ensure the deficient practice will not recur? **a. Semi Annually and randomly the DON will audit all nursing staff to insure practices are being followed and will retrain staff accordingly if necessary.** **b. DON or her designee will review the wasted or discontinued medication sign off sheet** **c. Controlled medication**	

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	An order summary for 1-1-19 through 3-11-19 indicated Resident C had a physician's order, dated 2-5-19, for Keflex 500 milligrams (mg) three times daily for 7 days for an unspecified infection. Review of the EMAR (electronic medical record) for February, 2019, indicated this medication was started on 2-6-19. The last two doses, on 2-13-19 for morning and afternoon, were indicated to have been attempted to be administered by LPN 7 and coded as a "9," indicative of "other/see progress notes." The corresponding progress notes for 2-13-19 at 11:07 a.m., indicated "ATB [antibiotic] complete." Another entry the same date at 11:21 a.m. indicated, "Stated his stomach was upset and he may come back to to get it," not specifying what medication was being referenced. However, the EMAR did not list any other medications due at that date or time. The clinical record was unclear if Resident C did or did not receive the last two doses of the ordered antibiotic medication. 3. The clinical record of Resident J was reviewed on 3-12-19 at 9:10 a.m. Her diagnoses included, but were not limited to polyarthritis and anxiety. Her active orders, effective as of 1-7-19 included, but were not limited to, Percocet 10/325 mg three times daily as needed for pain. The EMAR for 1-7-19, indicated Resident J received this medication one time at 11:57 a.m. from LPN 11. Her "Controlled Medication Count Sheet," for Percocet 10/325 mg indicated she had received this medication on 1-7-19 at 12:00 p.m., by LPN 11 and at 8:30 p.m. by LPN 7. It also indicated on 1-7-19, with no time listed, as having two tablets of this medication listed as "wasted" by LPN 4. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated, "I'm still not sure I understand the exact details but [name of		**binder will be maintained and reviewed by DON weekly** **d. DON or designee will review Antibiotic count sheets (attachment)** **i. Daily for 30 days** **ii. Every other day for 30 days** **iii. Weekly for 6 weeks** iv. **Randomly thereafter** 5. By what date the systemic changes will be completed? **a. completed 3/28 & 3/29/2019**	

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	LPN 4] had signed out as 'wasted' two Percocet 10/325 milligrams [mg] on [name of Resident J]. But [LPN 4] also marked out two doses of Norco 10/325 mg that [name of LPN 11] had given to [name of Resident K], all on 1-7-19. The issue was she [LPN 4] was not upfront with the Administrator about the count being off and trying to fix it, falsify, the error." The Corporate Nurse indicated a narcotic that is "wasted" or disposed of requires two nurses in order to complete the task and to have another licensed nurse to observe this and both nurses are to sign off on the narcotic record and this did not occur. An "Employee Discipline Report," form, dated 1-10-19, indicated on 1-7-19, LPN 4 did not communicate a medication error with the Administrator and falsified records "to cover up the error." 4. The clinical record of Resident K was reviewed on 3:00 p.m. Her diagnoses included, but were not limited to unspecified pain and anxiety. Her active orders, effective as of 1-7-19 included, but were not limited to, Norco 10/325 mg every 4-6 hours as needed for pain. The EMAR for 1-7-19, indicated Resident K received this medication two times, at 6:40 a.m. and at 11:25 a.m., from LPN 11. Her "Controlled Medication Count Sheet," for Norco 10/325 mg indicated she received this medication on 1-7-19 at 6:45 a.m., from LPN 11, at 11:30 a.m., from LPN 11, at 3:00 p.m., from LPN 4 and at 6:30 p.m. from LPN 4. This form had a line marked through the entries for 1-7-19, at 6:45 a.m. and at 11:30 a.m. In an interview with the Corporate Nurse on 3-12-19 at 11:00 a.m., she indicated, "I'm still not sure I understand the exact details but [name of LPN 4] had signed out as 'wasted' two Percocet 10/325 milligrams [mg] on [name of Resident J].			

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SENIOR SUITES AT THE LELAND, LLC	900 SOUTH A STREET RICHMOND, IN 47374

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	But [LPN 4] also marked out two doses of Norco 10/325 mg that [name of LPN 11] had given to [name of Resident K], all on 1-7-19. The issue was she [LPN 4] was not upfront with the Administrator about the count being off and trying to fix it, falsify, the error." The Corporate Nurse indicated a narcotic that is "wasted" or disposed of requires two nurses in order to complete the task and to have another licensed nurse to observe this and both nurses are to sign off on the narcotic record and this did not occur. An "Employee Discipline Report," form, dated 1-10-19, indicated on 1-7-19, LPN 4 did not communicate a medication error with the Administrator and falsified records "to cover up the error." On 3-12-19 at 1:55 p.m., the Corporate Nurse provided a copy of a policy entitled, "Medication Error Policy and Procedures," with an approval date of 11-1-17. This policy indicated, " Medication error means a discrepancy between what the physician ordered and what was not administered. Medication errors are to be brought to the prompt attention of the Director of Nursing or Nurse Manager. Contact the attending physician immediately of any adverse reactions. All medication errors must be brought to the attention of the Regional Nursing Director. Medication Errors require that the following course of action be followed: Immediately note the time and obtain a full set of Vital Signs; call/page attending physician for direction and orders; Contact and inform DON/Nurse manager; If necessary, call EMT; If alert, explain the incident to the resident; Contact family or other responsible party; Call hospital and give a full detailed report of incident; Chart in detail in the resident's medical record; Identify everyone notified and time..."			

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	03/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	This Residential tag relates to Complaint IN00287960. 2.5-8.1(a)(1) 2.5-8.1(a)(2)			