STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
ANDILAN	or condition	DENTIFICATION NUMBER.	B. WI		<u>uu</u>	11/02/2017	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 900 SOUTH A STREET RICHMOND, IN 47374				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	T	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R 0000							
Bldg. 00	Licensure Survey Investigation of C Complaint IN002 State Residential R0297 and R029 Survey dates: O November 1 and Facility number: Residential Cens These State Resi cited in accordance	ctober 31, 2017. 2, 2017. 012497	R 00	000			
R 0297	410 IAC 16.2-5-6(Pharmaceutical Se	c)(1) ervices - Noncompliance					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 1 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORR	RECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
			B. WI	NG		11/02/2017	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDE	R OR SUPPLIER				UTH A STREET		
SENIOR SUITES	S AT THE LE	ELAND, LLC		RICHMOND, IN 47374			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
· ·	EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE AF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
Bldg. 00 (c) If t admin facility (1) Ma pharm provide mediculaws of Based facility the plus of resistantial for Residual f	the facility consisters medic y shall do the ake arrangen naceutical sede residents we cations in according for interview of Indiana. In the facility failed to charmacy in idents review ces (Resident ings include eview of the facility failed to charmacy in idents review of the facility failed to charmacy in idents review of the facility failed to charmacy in idents review of the facility failed to charmacy in idents review of the facility failed to charmacy in ingressions. The resident B did not uno suppressions for the antivity of the antivity failed to fail the facility failed to charmacy in the facility failed to charmacy in the fa	ntrols, handles, and ations for a resident, the following for that resident: nents to ensure that rvices are available to with prescribed fordance with applicable ew and record review the obtain medication from a timely manner for 2 of wed for pharmacy at B and Resident D).	R 02		State Plan of Correction: Deficiency R297 What corrective action (s) will accomplished for those resider found to be affected by the deficient practice; 1. Facility has contracted vanew pharmacy, Care One (expertise is in long term care and assisted living communities of 10/26/2017. Residents continue to have choice for the pharmacy needs. How will the facility identify oth residents having the potential to be affected by the same deficie practice and what corrective action will be taken; 2. Any orders for medication from non-contracted pharmacie will be handled in compliance will be handled in compliance will be handled in compliance to the medication ordering policy Non-Contracted Pharmacies (sattached). Residents who are now with Care One pharmacytheir medications will be electronically reordered as the are integrated with our new system, Point Click Care. (see attached) What measures will be put integrated or what systemic change	nts vith es) eir to ent ons es with for see	11/30/2017

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 2 of 13

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/02/2017
	PROVIDER OR SUPPLIER		900 SC	ADDRESS, CITY, STATE, ZIP CODE DUTH A STREET	
		·		1OND, IN 47374	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	The nursing noted 10/2/17, a call we physician for presimmunosuppressible. The nursing noted 10/12/17, the physician for presimmunosuppressible. The nursing noted 10/12/17, the physician combinantiretroviral drumedication cycled in the physician for president physician for physician's recape but were not limedisorder, anxiety this record indication for physician's recape for physician'	e for Resident B, dated as placed to the escription for the sive drug as soon as e for Resident B, dated armacy was notified that ation drug and ag was not sent in the e change. desident B on 11/1/17 at sident did not always cation from the facility in ordered. The record was reviewed on 2 a.m. His diagnoses his October 2017 ontulation orders included ited to, major depressive and diabetes mellitus.		the facility will make to ensu that the deficient practice do not recur; 3. Initiated new medicati order policy and procedure freordering medications. Entimedication administration st will be oriented to new policy 11/30/17. (Please see attack How the corrective action (see monitored to ensure the deficient practice will not recure the deficient practice deficien	DATE re les on for re aff y by hed.)) will eur; ained tus of t of int ft to
	September 2017 not received his	*		Assisted Livir	
	of September 1s day shift. This r	a day from the evening t through September 9th esulted in 16 missed ot received his oral		G-123 Policy & Procedure	X
		ion prescribed twice a September 2nd through		Policy Title: Medication Order	ring

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 3 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
			B. W	ING		11/02/2017
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R			OUTH A STREET	
	SUITES AT THE L			RICHMOND, IN 47374		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	,	DATE
	_	, and on evening shift			(Non-Contracted	
	_	and September 5th			Pharmacy)	
		tember 17th. His record			Delieva Madientiene (new	
		not self-administer his			Policy: Medications (new	
	medications.				order and refills) and any	
					related equipment and	
	During an interv	view with Resident D on			supplies are ordered from	
	11/2/17 at 9:37	a.m., he voiced he had			the contracted pharmacy	
	went without his	s psychiatric medication			agreed upon between the	
	for 7 days last m	nonth because it had not			pharmacy and the facility	
	<u>-</u>	pharmacy and staff had			The facility medical staff	
		ey were waiting on it.			will maintain accurate	
					records of all medications	
	During an interv	view with the DON on			and supplies ordered and	d
		p.m., she explained			received.	
	Resident D had	• •				
					Procedure: 1.Fax new	/
	benzodiazepine				orders and refills to the	
		rescribed in September			pharmacy for all	
		e facility had not been			medications including	
		e medications from			non-prescription and ove	r
	pharmacy.				the counter medications.	
					2.New orders are to	be
		policy provided by QMA			entered into the Point Cli	ck
	1 on 10/31/17 at	t 12:26 p.m., included the			Care system into the	
	following: The	Pharmacy provider duties			medication order portal o	f
	included, but we	ere not limited to,			the resident's profile.	
	accurately dispe	ensing prescriptions based			3.Refills will be	
	on the authorize	d prescriber orders and			requested when there is	a
		and timely pharmacy			7-day supply of medication	ons
	services.	J . J			left in med cart to allow for	or
					the timely receipt of the	
	These State Res	idential tags relate to			medication.	
	Complaint IN00	•			Refill requests should	be
	Complaint 1100	1430733.			documented onto a	

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 4 of 13

PRINTED: 11/28/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 11/02/2017	
	ROVIDER OR SUPPLIER		900 SC	ADDRESS, CITY, STATE, ZIP CODE DUTH A STREET IOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				progress note and continued documentation on shift report until received. If no information regarding the refill is received with 24 hours the Director of Nursing or Nursing Manager is to be informed. Contact the pharmacy follow up communication and information. 4. Urgent or STAT orders are to be faxed and followed up with telephoric communications with the pharmacy to satisfactorily convey the urgency. Urgent or stat medications needed while awaiting receipt from non-contracted pharmacy can be obtained via the Emergency Medication B with approval from the facility contracted pharmacy. Nurse obtaining medication out of the Emergency Medication B is to fill out form in box armust include insurance information for any resident not regularly receiving	e for d he y ox ox nd	

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 5 of 13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 11/02/2017
NAME OF PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE DUTH A STREET	•
SENIOR SUITES AT THE L	ELAND, LLC	900 SC RICHM		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFRENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG REGULATORY OF	(CEC IDENTIFYING INFORMATION)	TAG	medications from contracted pharmacy. Fathis form to facility contracted pharmacy. 1.Discontinued and changed orders are to be entered into the Point Cl Care system accordingly and then faxed to the non-contracted pharmac for proper processing. Assisted Livin	e lick y
			G-122 Policy Procedure	y & <u> </u>
			Policy Title: Medication Orderir (Contracted Pharmacy) Policy:Medications (new order and refills) and an related equipment and supplies are ordered fro the contracted pharmacy agreed upon between the pharmacy and the facility medical staff will maintain accurate	m y as ne y.

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PRINTED: 11/28/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 11/02/2017
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
SENIOR	SUITES AT THE LE		RICHM		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	records of all medications and supplies ordered and received. Procedure: 1. New orders are to entered into the Point Clic Care system into the medication order portal of the resident's profile. This will start the new order process. The pharmacy will receive the new order via this system. The system will indicate whether or not the pharmacy requires that the order also be faxed to the pharmacy. 2. Refills will be requested when there is 7-day supply of medication left in med cart to allow for the timely receipt of the medication. Refill requests show be documented onto a progress note and continued documentation on shift report until received. If no information regarding the refill is received with 24 hours the Director of Nursing or	be ck f e e a ons or uld

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 7 of 13

PRINTED: 11/28/2017 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED 11/02/2017	
	ROVIDER OR SUPPLIER		900 SC	ADDRESS, CITY, STATE, ZIP CODE DUTH A STREET IOND, IN 47374		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
				Nursing Manager is to be informed. Contact the pharma for follow up communicate and information. 3.Urgent or STAT orders are to be faxed and followed up with telephore communications with the pharmacy to satisfactorily convey the urgency. Urgent or stat medications needed can obtained via the Emerger Medication Box with approval from the facility contracted pharmacy. Nurse obtaining medication out of the Emergency Medication Bis to fill out form in box are fax this form to facility contracted pharmacy. 1.Discontinued and changed orders are to be entered into the Point Clic Care system accordingly Pharmacy will be automatically notified according to what is entered into this system. 2.All residents medications will be updated, changes made and new medications ser	acy ion and he was a contract of the contract	

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 8 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETED			ETED		
			B. WING			11/02/	2017
	ROVIDER OR SUPPLIER		90	00 SOL	ET ADDRESS, CITY, STATE, ZIP CODE SOUTH A STREET HMOND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID I				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	.G	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	_	DATE
					according to information printo the Point Click Care system, medications ordering portal.	out	
R 0298	410 IAC 16.2-5-6(, , ,					
Bldg. 00	(2) A consultant plend employed, or under (A) be responsible in 856 IAC 1-7; (B) review the drug practices in the fact (C) provide consult procedures of order administering, and well as medication (D) report, in writing his or her designed dispensing or admit (E) review the drug receiving these se sixty (60) days.	er contract, and shall: If for the duties as specified g handling and storage cility; tation on methods and ering, storing, I disposing of drugs as I record keeping; Ing, to the administrator or e any irregularities in inistration of drugs; and g regimen of each resident rvices at least once every					
	facility failed to review of medica 6 of 6 residents r services (Resident Findings include		R 0298		State Plan of Correction: Deficiency R298 1.Describe what the facility d to correct the deficient practice for each client cited in the deficiency. Answer: The facility has contracted with a new consulting the contracted with a new contracte	ng	11/30/2017
	provided by the 10:40 a.m., Resident and 2017. Resident and 2017.	Pharmacy review facility on 11/2/17 at dent B, C, D, and F last been reviewed June A and E medications had d. The Regional			pharmacy, Care One. The new pharmacy will conduct every 60 days a review of every residen receiving medications in the facility. 2. Describe how the	0 t	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 11/02/2017		
	PROVIDER OR SUPPLIER		900	EET ADDRESS, CITY, STATE, ZIP CODE D SOUTH A STREET CHMOND, IN 47374	
	SUITES AT THE LI SUMMARY S (EACH DEFICIENT REGULATORY OR Nursing Director pharmacy review During an interview on 11/2/17 at 1:2 was unsure where reviewed the rest the facility, but 1/2017. During an interviewed the rest the facility of the facility			PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IT CROSS-REFERENCE) TO THE APPROP DEFICIENCY) facility reviewed all clients in facility that could be affected the same deficient practice, state, what actions the facility took to correct the deficient practice for any client the facility dentified as being affected. Answer: The new pharma will conduct every 60 days pharmacy reviews on every resident residing in facility receiving medications begin November 29 & 30, 2017. 3. Describe the sor systemic changes the facility make to enthat the deficient practice do	To the d by and ty cility accy aning steps cility asure
	on 10/31/17 at 1 resident's diagnor not limited to, di knee joint, insort fibromyalgia, lo anticoagulants, e hypertension and did not self adm. 2.) Review of th on 11/1/17 at 9:0 resident's diagnor not limited to, H Virus (HIV) disorder, edeman migraine and vit			not recur, including any in-services but this also sho include any system changer made. Answer: The facility has instituted a new policy and procedure related to the consultant pharmacy's 60-d review visits and reports (se attachment). The Facility Administrator and Director of Nursing, have reviewed the and will ensure the training following of policy/procedure of the consulting pharmacy will begin this mode November 29, 2017 and the continue every 60 days ong	ay ee of policy and ee.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			VEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			D	
			B. W	ING		11/02/201	7
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			900 SO	OUTH A STREET		
SENIOR	SUITES AT THE LE	ELAND, LLC		RICHM	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	4	TAG			DATE
	medications.				4. Describe how the	9	
					corrective action(s) will be monitored to ensure the deficie	ont	
	3.) Review of the	e record of Resident C on			practice will not recur, i.e., wha		
	11/1/17 at 9:40 a	.m., indicated the			quality assurance program will		
	resident's diagno	ses included, but were			put into place.		
		eart failure, overactive			Answer:		
	bladder, nausea,				• • • • • • • • • • • • • • • • • • •	,	
		a, severe protein-calorie			Administrator and the Director		
		pertension and chronic			Nursing will receive copies of t pharmacist reports timely	i i c	
		C did not self administer			following every 60-day review.		
	medications.	e did not sen administer			• • • • • • • • • • • • • • • • • • •		
					Nursing in 5-7 days of receipt	of	
	· /	record was reviewed on			report, will review the entire		
		2 a.m. His diagnoses			report. Any recommendations	will	
	documented on l				be forwarded to the attending physician for any possible		
	1	pitulation orders included			medication changes.		
		ited to, major depressive			Any medication changes recei	ved	
	disorder, anxiety	r, insomnia, essential			from the prescriber will be		
	hypertension, dia	abetes mellitus,			documented and carried out		
	constipation, slee	ep apnea, anemia,			according to facility policy.		
	allergic rhinitis,	disease of the upper					
	respiratory tract,	gastroesophageal reflux			Assisted Living		
	disease, angina,	heart failure, shortness of					
	breath, edema, v	itamin deficiency, and					
	hypokalemia.	•			G-111 Policy	,	
					& Procedure		
	· ·	record was reviewed on			a Flocedule		
	10/31/17 at 1:51	p.m. His diagnoses			D II TIII		
	documented on h	nis October 2017			Policy Title: 60 day		
	physician's recap	oitulation orders included			Pharmacist Review Policy	/	
	but were not lim	ited to, dementia with			and Procedure		
		bance, depressive			Dollow The Facility will		
	disorder, convul				Policy:The Facility will		
	•	vitamin deficiency, dry			contract with a pharmacy		
		ssential hypertension,			for the purposes of 1.		
	-j = 5j 11d1 01110, 0	Dervension,					

State Form Event ID: P52711 Facility ID: 012497 If continuation sheet Page 11 of 13

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
			B. WI	NG		11/02/	2017
				CTD FFT A	DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
CENIOD	CUITEC AT THE L	FLAND LLC			UTH A STREET OND, IN 47374		
SENIOR	SUITES AT THE LI	ELAND, LLC		RICHIVI	OND, IN 47374		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	varicose veins, g	gastroesophagel reflux			Providing medications to		
	disease, constipa	ation, hemorrhoids,			the facility for facility staff		
	overactive bladd	ler, shortness of breath,			medication administration	1	
	and pain.	,			to the residents residing i	n	
	una pum.				the facility or resident		
	() Dogidant Ela	managed arrog marriages d am			self-administration and 2.		
		record was reviewed on			Consultation on methods		
		a.m. Her diagnoses				20	
		her October 2017			and procedures of ordering	•	
		pitulation orders included			storing, administering and		
	but were not lim	ited to, dementia, major			disposing of medications	as	
	depressive disorder, insomnia, overactive				well as medication		
	bladder, hypothy	yroidism, vitamin			recordkeeping and to		
	deficiency, dry				review medication handling	ng	
	1	nstipation, rhinitis, spinal			and storage practices.		
	-	ımbar region, hiatus					
					Procedure:The consulting	3	
		hypertension, angina		Pharmacist will:			
	pectoris, heart d	isease, and pain.			·Review the medication		
					regimen of each resident		
	The Pharmacy p	olicy provided by QMA			receiving medication		
	1 on 10/31/17 at	12:26 p.m., included the			administration services at	·	
	review of medic	ation regimen of each			least once every 60 days	-	
		quarterly or as defined by			Provide to the facility a		
		regulations to identify			_		
		actual medication-related			report of any irregularities	111	
					the dispensing or		
	problems, include	_			administration of		
		roper drug selection,			medications.		
	_	dosage, failure to receive			·Report will be submitte	ed	
	drugs, overdosag	ge, adverse drug reaction,			to the Administrator or		
	drug interactions	s, and drug usage without			Director of Nursing		
	indication.				_		
					The Director of Nursing w	/ill:	
	These State Resi	idential tags relate to			Review pharmacists		
	Complaint IN00	_			report with 5-7 days post		
	Complaint into	430733.			receipt		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUI	A. BUILDING 00		COMPLETED		
				B. WING		11/02/2017		
			<u> </u>	_		11/02/	2017	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
				900 SOUTH A STREET				
SENIOR SUITES AT THE LELAND, LLC				RICHMOND, IN 47374				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (X		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG		DATE		
					·Forward any			
				recommendations to the				
					medications prescriber or			
					the residents attending			
					physician			
					Document and act upon			
					any medication changes			
					received from the prescriber			
					according to facility policy. ·Will contact the prescriber directly via			
					telephone or fax if no			
					response is received			
					· -			
					regarding the pharmacy			
					recommendations within	30		
					days.			
					·Document all contact			
					attempts made to the			
					prescriber on the residen	ıt's		
					medical record.			

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