

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2023
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NAME OF PROVIDER OR SUPPLIER  BRIDGE AT GARDEN PLAZA	STREET ADDRESS, CITY, STATE, ZIP COD 8614 W 10TH ST INDIANAPOLIS, IN 46234
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R 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00409956.</p> <p>Complaint IN00409956 - State Residential deficiencies related to the allegations are cited at R0241, and R0242.</p> <p>Survey date: June 12, and 13, 2023</p> <p>Facility number: 005616</p> <p>Residential Census: 70</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed June 23, 2023.</p>	R 0000		
R 0241  Bldg. 00	<p>410 IAC 16.2-5-4(e)(1) Health Services - Offense</p> <p>(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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent (%) when 30 errors out of 36 opportunities for errors were observed during medication administration for 3 of 7 residents observed (Residents D, G, and W) resulting in an error rate of 83.3%, and an error rate of 100% for 15 of 15 residents not observed for the 8:00 a.m. medication pass but medications</p>	R 0241	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. <b>What corrective action(s) will be accomplished for those residents found to have been</b>	08/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Marque McKinnor	Administrator	07/13/2023

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>were administered late (Residents B, C, E, F, H, J, K, L, M, N, P, Q, R, S, and T ).</p> <p>B. Based on observation, interview, and record review, the facility failed to manage residents with diabetes by administering insulin injections timely and documenting interventions for blood sugar readings over 130 (normal blood sugar range 90 to 130 for adults) for 4 of 4 residents reviewed for insulin administration (Residents U, W, X, and Y).</p> <p>Findings include:</p> <p>A. On 6/12/23 at 10:14 a.m., Resident W was observed lying in bed, indicated she was waiting on her morning medications. She had received her insulin that morning but Qualified Medication Aide (QMA) 5 did not bring her medications. Resident W indicated if she went down to the dining room for lunch, she could not have her morning medications until she got back. When asked when she was supposed to have received her morning medications she indicated, "well long before now."</p> <p>On 6/12/23 at 10:33 a.m., QMA 5 was observed in the 3rd floor nurse's station. She indicated she was finished with her assignment of administering morning medications to half of the 2nd floor and the entire 3rd floor residents, to include Resident W. When told the resident said had not had her morning medications this morning, QMA 5 checked the electronic medication administration record (eMAR) and indicated "oh yeah, I did not give her morning medications yet." Observation of the eMAR indicated Resident W's medications were highlighted in red. QMA 5 indicated, if a resident's name and/or medications were highlighted in red, that meant the medications were late. She was not exactly sure when all the</p>		<p><b>affected by the deficient practice;</b> A medication administration audit has been completed for Residents B, C, D, E, F, G, H, J, K, L, M, N, P, Q, R, S, T, W, X &amp; Y.</p> <p><b>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;</b> All residents have the potential to be affected by this deficiency. Nursing personnel responsible for administering medication will be in-serviced by the Director of Nursing on following medication administration policy. Upon hire, all qualified Nursing personnel will review the medication administration policy.</p> <p><b>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</b> The Director of Nursing or designee will review the MAR weekly to ensure the procedure is being followed by all designated Nursing personnel administering medications. All designated Nursing personnel will be in-serviced regarding this practice. Upon hire, all qualified Nursing personnel will review the medication administration policy.</p>	

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	<p>medications were due, some had times of 8:00 a.m. or 9:00 a.m. and some just indicated a.m. medications.</p> <p>QMA 5 indicated, she had not completed her morning medication pass timely this morning due to all residents' medications were due at the same time, and due to a recent state survey, the staff were no longer allowed to leave medications at the resident's bedside or pass medications in the main dining room. Therefore, she had to "hunt them [residents] down."</p> <p>On 6/12/23 at 11:20 a.m., observation of the 2nd and 3rd floor eMAR used by QMA 5 for the 8:00 a.m. medication pass, indicated 17 of her 38 residents were highlighted in red as the medications not having been administered to include, Residents B, C, D, E, F, G, H, J, K, L, M, N, P, Q, R, S, and T.</p> <p>On 6/12/23 at 11:25 a.m. Resident R's care giver approached QMA 5 in the nurse's station and indicated the resident was really upset she had not gotten her morning meds, and she had already gone to the main dining room for lunch.</p> <p>Confidential interviews were conducted during the survey:</p> <p>a. Indicated the resident self-administered medications. When the facility staff were administering medications had been caught in at least 12 medication errors. Had an order for Warfarin, and an outside laboratory drew labs on a routine basis. Staff were not always prompt in relaying lab results and new medication dose changes or holds, they had to be reminded for the resident to get them.</p> <p>b. Indicated resident was not happy as she rarely got her medications timely. Staff used to leave her</p>		<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur /i.e., what quality assurance program will be put into place;</b> Director of Nursing will complete 100% medication administration audits to ensure each designated Nursing personnel is compliant per the policy. Findings will be documented using the QA tool entitled "Nursing- Medication Administration Shadowing" to ensure compliance. If 95% threshold is not achieved, an action plan will be developed.</p>	

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	<p>medications at bedside, but they no longer did that. Indicated concerns had been taken to the ED without success, it just got her labeled as a troublemaker.</p> <p>Observation of the 8:00 a.m. medication pass on 6/12/23 and 6/13/23, indicated 3 of 7 residents' medications were administered after the 1 hour before or after policy to include:</p> <p>1. On 6/12/23 at 11:00 a.m., QMA 5 was observed to administer 9 of 10 medications to Resident W that were ordered for 8:00 a.m. The medications included aspirin (nonsteroidal anti-inflammatory drug and blood thinner) 81 mg, chlorthalidone (diuretic used to treat high blood pressure and fluid retention) 25 mg, donepezil HCl (cognition-enhancing medication used to treat Alzheimer's disease) 10 mg, glimepiride (used to treat type 2 diabetes) 2 mg, losartan potassium (used to treat high blood pressure) 100 mg, metoprolol succinate ER (used to treat chest pain and high blood pressure) 50 mg, nitrofurantoin (antibiotic to treat urinary tract infection) 100 mg, tramadol (narcotic pain reliever for moderate to severe pain) 50 mg, and vitamin D 3 (supplement) 5000 U/1.2 mg. Acetaminophen (analgesic) 325 mg was unavailable.</p> <p>Resident W's chart was reviewed on 6/13/23 at 2:00 p.m. Diagnoses on Resident W's profile included, but were not limited to, hypertension (high blood pressure), type 2 diabetes mellitus (adult onset diabetes where the body doesn't produce enough insulin or is insulin resistant), anxiety disorder (feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), chronic kidney disease (long lasting disease of the kidney leading to renal failure and waste build up), and hypothyroidism (underactive thyroid with symptoms of intolerance to cold, feeling of tiredness, slow heart</p>			

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	<p>rate, depression, and weight gain).</p> <p>Resident W's medical record to include the MAR and Progress Notes, dated 6/13/23, indicated no documentation to indicate the resident's medications were administered late, or the physician notified.</p> <p>2. On 6/12/23 at 11:13 a.m., QMA 5 was observed to administer 9 medications to Resident G that were ordered for 8:00 a.m. The medications included diclofenac sodium topical (reduces pain, swelling, and joint stiffness from arthritis), acetaminophen 500 mg, aspirin 81 mg, calcium 600 + D3 (treats conditions caused by low calcium levels such as osteoporosis), duloxetine (antidepressant) 30 mg, metoprolol tartrate 25 mg, pantoprazole (treats esophageal reflux/heartburn) 40 mg, senna (stool softener/laxative) 8.5 mg, and Tab-A vitamin (dietary supplement).</p> <p>Resident G's record was reviewed on 6/13/23 at 2:45 p.m. Diagnoses on Resident G's profile included, but were not limited to, osteoporosis (condition in which bones become weak and brittle), hypothyroidism, glaucoma (nerve connecting the eye to the brain is damaged, usually due to high eye pressure, can lead to blindness), hypertension (high blood pressure), Parkinson's disease (disorder of the central nervous system affecting movement, can cause tremors), major depressive disorder (causes a persistent feeling of sadness and loss), gastro-esophageal reflux disease (GERD-heart burn), anemia (lack of healthy red blood cells), hypokalemia (below normal levels of potassium can result in fatigue, muscle cramps, and abnormal heart rhythm), and atrial fibrillation (rapid, erratic heart rate intermittent or suddenly stops on its own).</p>			

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	<p>Resident W's medical record to include the MAR and Progress Notes, dated 6/13/23, indicated no documentation to indicate the resident's medications were administered late, or the physician notified.</p> <p>3. On 6/12/23 at 11:31 a.m., QMA 5 was observed to administer 10 of 11 medications to Resident D that were ordered for 8:00 a.m. The medications included Eliquis (blood thinner to treat or prevent blood clots) 5 mg, amlodipine besylate (treats high blood pressure) 5 mg, amlodipine besylate 2.5 mg, clopidogrel 75 mg, levothyroxine (treats hypothyroidism, enlarged thyroid, or thyroid cancer) 75 micrograms (mcg), metoprolol succinate ER 100 mg, pantoprazole 40 mg, losartan 100 mg, fluticasone propionate nasal suspension (treats non-allergy nasal symptoms such as sneezing, runny or stuffy nose) 50 mcg, and Synthroid 75 mcg. Claritin (treats allergy symptoms and hives) 24 hour was unavailable, QMA 5 indicated the pharmacy may have taken it when delivering the weekly medication supply.</p> <p>Resident D's medical record to include the MAR and Progress Notes, dated 6/13/23, indicated no documentation to indicate the resident's medications were administered late, or the physician notified.</p> <p>On 6/12/23 at 11:32 a.m., Resident D's family member was observed in the resident's room visibly upset with her arms crossed over her chest. Indicated, she was upset as meds so late, that the situation was totally unacceptable, and she had already taken her concerns to the ED, and nothing was getting better. When the family member asked QMA 5 why the medications were late this date, QMA 5 indicated it was due to</p>			

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	<p>multiple reasons to include her having a resident actively dying, but mostly due to the Indiana Department of Health (IDOH) had made a bunch of changes so it was their fault. The family member indicated the resident had requested his medications be given between 7:00 a.m. and 8:00 a.m., then his medications ordered every 12 hours could be administered between 7:00 p.m. and 8:00 p.m. But instead, he was getting his medications later in the morning, and then was being woken up at night after he was asleep to get his medications. The family member indicated, most worrisome was him not getting his blood thinner Eliquis timely.</p> <p>During an interview on 6/13/23 at 11:48 a.m., Licensed Practical Nurse (LPN) 7 indicated, morning meds were listed 6:00 a.m. - 10:00 a.m., so staff had an hour before and hour after to finish, and it usually took her the entire time due to the number of residents, some were slow due to the number of medications, and some residents had to be found. Staff were no longer allowed to administer medications in the dining room, so she would give as many as possible before breakfast and catch the rest when they got back to the floor.</p> <p>On 6/13/23 at 3:25 p.m., the ED indicated he was unable to locate medication administration education for QMA 5, although he knew it had been completed upon hire.</p> <p>B. Confidential information obtained during the survey indicated, the Wellness Director gave insulin to a resident around 2:00 p.m. that was due at 11:00 a.m.</p> <p>On 6/12/23 at 9:45 a.m., QMA 4 indicted there were currently 3 residents in the facility receiving insulin, Residents U, X, and W. There were 2 medications passers in the facility, and the insulin</p>			

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	<p>administration was split between them. Nurses administered insulin, and there were some of the QMA's qualified to also administer insulin.</p> <p>On 6/12/23 at 2:03 p.m., QMA 6 indicated there were 4 residents in the facility currently with insulin orders to include Residents U, W, X, and Y.</p> <p>1. A physician's order for Resident U, Lantus (long acting insulin to treat diabetes, onset 1.5 to 2 hours) SoloStar Solution Pen 100 unit/ml inject 32 units subcutaneous at bedtime for diabetes.</p> <p>A physician's order for Resident U, Kenalog (fast acting insulin to treat diabetes, onset within 30 minutes of injection) KwikPen Solution 100 unit/ml inject 3 units three times daily (TID) in a.m., midday, and p.m. for type 2 diabetes mellitus.</p> <p>Medication Administration Record for Resident U, dated June 2023, indicated 4 missed doses of Kenalog insulin, and 13 of 42 doses of insulin were administered between 3 minutes to in excess of 4 hours late.</p> <p>Blood sugar monitoring summary for Resident U, dated June 2023, indicated documentation 38 of 47 blood sugar readings were over 160 milligrams (mg), high readings from 142 - 373. (Normal blood sugar range 90 to 130 for adults).</p> <p>The resident record lacked documentation Resident U had a care plan for diabetes management.</p> <p>2. A physician's order for Resident W, Lantus SoloStar Solution Pen 100 unit/ml inject 26 units subcutaneous at bedtime for diabetes.</p>			

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	<p>A physician's order for Resident W, Kenalog KwikPen Solution 100 unit/ml inject 8 units with meals at 8:00 a.m., 12:00 p.m., and 5:00 p.m. related to type 2 diabetes mellitus.</p> <p>Medication Administration Record for Resident W, dated June 2023, 29 of 45 doses of insulin were administered between 12 minutes to in excess of 5 hours late.</p> <p>Blood sugar monitoring summary for Resident W, dated June 2023, indicated documentation 50 of 50 blood sugar readings were high readings from 150 - 355.</p> <p>A care plan for Resident W indicated diabetic care. The goal was for the resident to have no complications related to diabetes, and to receive medications safely and as prescribed. Interventions included administer medications as ordered by MD. Oversee any possible side effects and effectiveness and report observed side effects/effectiveness to nurse. Encourage resident to manage good health practices.</p> <p>3. A physician's order for Resident X, Humulin 70/30 (intermediate-acting insulin used to treat diabetes, starts to work in 2 to 4 hours, peaks in 4 to 12 hours) KwikPen 100 unit/ml inject 14 units subcutaneous in the morning for diabetes.</p> <p>A physician's order for Resident X, Humulin 70/30 KwikPen 100 unit/ml inject 12 units subcutaneous in the afternoon at 4:00 p.m. for type 2 diabetes.</p> <p>Medication Administration Record for Resident X, dated June 2023, indicated 1 missed doses of Humulin insulin, and 14 of 23 doses of insulin were administered more than 1 to over 5 hours late.</p>			

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	<p>Blood sugar monitoring summary for Resident X, dated June 2023, indicated documentation 31 of 31 blood sugar readings were high readings from 165 - 474.</p> <p>A care plan for Resident W indicated diabetic care. The goal was for the resident to have no complications related to diabetes, and to receive medications safely and as prescribed. Interventions included administer medications as ordered by MD. Oversee any possible side effects and effectiveness and report observed side effects/effectiveness to nurse. Blood sugar checks as ordered by MD.</p> <p>4. A physician's order for Resident Y, Lantus SoloStar Solution Pen 100 unit/ml inject 25 units subcutaneous at bedtime for type 2 diabetes mellitus.</p> <p>Medication Administration Record for Resident Y, dated June 2023, indicated 6 of 11 doses of insulin were administered more than 1 to over 2 hours late.</p> <p>Blood sugar monitoring summary for Resident Y, dated June 2023, indicated documentation 12 of 12 blood sugar readings were high readings from 137 - 188.</p> <p>A care plan for Resident Y indicated diabetic care. The goal was for the resident to have no complications related to diabetes, and to receive medications safely and as prescribed. Interventions included encourage to manage good general health practices.</p> <p>On 6/13/23 at 1:45 p.m., the Executive Director (ED) provided a Medication Assistance Record</p>			

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R 0242 Bldg. 00	<p>policy, revised 8/22/22, and indicted the policy was the one currently being used by the facility. The policy indicated, "Medication assistance will be provided according to state regulations. Medication Assistance includes reminding, assisting, or administration of resident medications according to physician's orders and state regulations. Community will establish medication times unless otherwise directed by physician or healthcare provider ...1. Responsibility. Resident Care Director/designee are responsible for ensuring medication management according to physician orders ...Timeframe. Residents are assisted with medications within a 2-hour timeframe [i.e., one hour before and one hour after medication order time]. Medication Delivery Times. Resident Care Director/designee posts time of medications to be delivered according to community standard. State Regulations apply. Standardized 1-hour time frame delivery set up: AC = before meals PC= after meals QD = 8:00 a.m. BID = 8:00 a.m. 5:00 p.m. TID = 8 a.m., noon, 5:00 p.m. QID = 8:00 a.m., noon, 4 p.m., 8:00 p.m. Q 12 = 8:00 a.m., 8:00 p.m. HS = hour of sleep, bedtime Anticoagulants = 4:00 p.m. Flex time delivery setup ...AM = [Morning] time frame from 7:00 a.m. to 11:00 a.m. [e.g., daily medications] ..."</p> <p>This State tag is related to Complaint IN00409956.</p> <p>410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any</p>			

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	<p>undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record.</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician's orders were processed timely and anticoagulant medication doses were administered correctly for 1 of 3 residents observed for monitoring of anticoagulant medications (Resident B).</p> <p>Findings include:</p> <p>Confidential information obtained during the survey indicated, a faxed order was received from the physician for Resident B on 5/26/23 to hold her Warfarin (anticoagulant/blood thinner used to treat and prevent blood clots) for 3 days, then change the dosage. The order was not processed by the Wellness Director until 5/29/23 resulting in a "major" medication error.</p> <p>Resident B's record was reviewed on 6/12/23 at 2:36 p.m. Diagnoses on Resident B's profile included, but were not limited to, paroxysmal atrial fibrillation (rapid, erratic heart rate intermittent or suddenly stops on its own), thrombocytopenia (low number of platelets in the blood may cause trouble stopping bleeding), ischemic cardiomyopathy (narrowing of the arteries that supply blood to the heart), acute myocardial infarction (heart attack), and presence of cardiac pacemaker.</p> <p>An Approved Prescription fax received for Resident B, dated 5/26/23 at 12:26 a.m., indicated Warfarin 2 milligrams (mg) tablet. "I have adjusted the dose as follows: hold today's Warfarin dose, then 2 mg Saturday, 1.5 mg Sunday, 2 mg Monday</p>	R 0242	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> All designated Nursing personnel were in-serviced regarding proper procedure to ensure Physician Orders are processed timely. An audit has been conducted and completed for Resident B.</p> <p><b>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;</b> All residents have the potential to be affected by these deficiencies. To identify other residents having the potential to be impacted by the same deficiencies, a Physicians Order audit will be completed for 100% of residents who qualify. Resident Care Director or designee is responsible for ensuring medication management according to</p>	08/15/2023
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NAME OF PROVIDER OR SUPPLIER  BRIDGE AT GARDEN PLAZA	STREET ADDRESS, CITY, STATE, ZIP COD 8614 W 10TH ST INDIANAPOLIS, IN 46234
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	<p>- Thursday, retest 6/1/23." The resident's INR was 4.09. The Nurse Practitioner (NP) dated and signed the fax on 5/29/23.</p> <p>A physician's orders for Resident B, dated 5/12/23, indicated weekly PT/INR to be drawn every Monday from 5/12/23 through 5/12/2024 related to long term use of anticoagulants in the morning every Tuesday.</p> <p>A physician's order for Resident B, dated 5/29/23, indicated Warfarin sodium oral tablet 2 mg give 1 tablet by mouth in the evening every Monday, Tuesday, Wednesday, Thursday, Friday, and Saturday for anticoagulant.</p> <p>A physician's order for Resident B, dated 5/29/23, indicated Warfarin sodium oral tablet give 1.5 mg by mouth in the evening every Sunday for anticoagulant.</p> <p>A Medication Administration Record (MAR) for Resident B, dated May 2023, indicated the resident record lacked documentation to indicate new orders were followed to hold Warfarin sodium 2 mg on 6/26/23, administration of Warfarin sodium 1.5 mg on Sunday 5/28/23, or Warfarin sodium 2 mg on Monday 5/29/23.</p> <p>A laboratory test result for Resident B, collection date 5/23/23 at 2:34 p.m., indicated PT/INR (measures how long it takes for a clot to form in a blood sample) PT 48.6 (reference range 9.3 - 13.5) and INR 4.09 (reference range 0.75 - 1.26) both high results meaning the resident was at risk for dangerous bleeding. A handwritten note on the bottom of the report indicated 5/23/23 faxed to MD (physician). 5/25/23 the NP dated and signed the bottom of the report.</p>		<p>physician orders. Resident Care Director or designee will be in-serviced on the importance of obtaining the fall assessment upon notification monitoring process to be included in the service plan.</p> <p><b>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</b> Resident Care Director / designee conduct random EMAR reviews to ensure compliance with physician orders. Resident Care Director / designee are also responsible to ensure Medication Assistance Records are maintained accurately. Upon hire, all qualified Nursing personnel will review the medication administration policy.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place;</b> In addition to the Physicians order audit completed by the Director of Nursing, the Quality Assurance committee will audit a sample of records (no less than 5 charts) of residents admitted during the previous quarter and audit those records to ensure compliance with Physician orders. The Resident Care Director will be responsible</p>	

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	<p>A laboratory test result for Resident B, collection date 6/2/23 at 5:54 a.m., indicated PT 37.5 (reference range 9.3 - 13.5) and INR 3.19 (reference range 0.75 - 1.26) both continued high results. An unidentified signature on the bottom of the report indicated 6/2/23 faxed. On 6/6/23 the NP dated and signed the bottom of the report.</p> <p>A care plan for Resident B, dated 3/15/23, indicated the resident was receiving anticoagulant therapy. The goal was for the resident to reduce the risk of bleeding and bruising. Interventions included, follow orders for anticoagulant therapy, and staff would report any bleeding or bruising to the nurse.</p> <p>During an interview on 6/12/23 at 9:40 a.m., Qualified Medication Aide (QMA) 4 indicated, physician's orders received on the fax machine were processed by the nurse on duty. Days when there were only QMA's passing medications, the Wellness Director was responsible for processing the orders. Over the weekend there had been a nurse on duty so the orders were processed each day.</p> <p>During an interview on 6/13/23 at 11:48 a.m., Licensed Practical Nurse (LPN) 7 indicated, it was the responsibility of the nurse on duty to process new medication orders. If there were only QMA's passing medications, then the Wellness Director would process orders.</p> <p>On 6/13/23 at 3:15 p.m., the Executive Director (ED) indicated there was a nurse on duty every day, and it was the responsibility of the nurse to process new physician's orders and assure the resident was receiving the correct dose of her medications.</p>		for checking the records weekly for 3 months, then monthly 3 months. Findings will be documented using the Quality Management Performance Improvement tool entitled "Resident Care" to ensure compliance. If the desired threshold is not achieved, an action plan will be developed.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2023

FORM APPROVED

OMB NO. 0938-039

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	<p>On 6/13/23 at 1:45 p.m., the Executive Director (ED) provided a Medication Assistance Record policy, revised 8/22/22, and indicated the policy was the one currently being used by the facility. The policy indicated, "Responsibility: The Resident Care Director/designee are responsible for ensuring medication management according to physician orders. Resident Care Manager/designee are also responsible to ensure Medication Assistance Record are maintained accurately ...Confirmation with Physician's Order: The Medication Assistance Record is used for transcription of physician's orders ...New medications and physician order changed are transcribed onto MAR/MOR/eMAR [medication administration record/medication order record, electronic medication administration record] with date of order, date of transcription noting the transcriber ..."</p> <p>This State tag is related to Complaint IN00409956.</p>				