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	05/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
JOURNEY SENIOR LIVING OF VALPARAISO	74 E JOURNEY WAY VALPARAISO, IN 46383

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00295127. This visit was in conjunction to the Post Survey Revisit (PSR) to the PSR completed 4/23/19 to the Investigation of Complaint IN00288460 completed on 3/25/19. Complaint IN00288460 - Not corrected. Complaint IN00295127 - Substantiated. State Residential Findings related to the allegations are cited at R241 & R244. Survey dates: May 20 & 21, 2019 Facility number: 014081 Residential Census: 30 These State Residential Findings cited are in accordance with 410 IAC 16.2-5. Quality review completed on 5/29/19.	R 0000	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility is also requesting a desk review for compliance in these areas.	
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, record review, and interview, the facility failed to ensure Physician's	R 0241	R241	06/14/2019

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

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	Orders were followed related to medication administration for 2 of 8 residents observed during 1 Medication Pass Observation (Residents D & F) and 2 of 5 residents reviewed for Physician's Orders. (Residents B & G) Findings include: During an evening Medication Pass Observation on 5/20/19 at 5 p.m., LPN 1 indicated the medication pass times were A.M.: 5 a.m. - 11 a.m., Midday: 11 a.m. - 2 p.m., P.M.: 3 p.m. - 7 p.m., and HS (bedtime): 7 p.m. - 10 p.m. "The DON (Director of Nursing) has said medications can be set up for the entire shift. All medications have been set up and placed in the resident's slot in the Medication Cart." The Medication Pass Observation was completed by comparing the medications already set up to the medications still in the containers in which they were delivered to the facility. 1. On 5/20/19 at 5:09 p.m., LPN 1 removed the cup of medications in Resident D's slot in the Medication Cart, the medications were compared with the pills still in the original containers and then LPN 1 administered the medications to the resident, which included olanzapine (antipsychotic) 7.5 mg. Resident D's record was reviewed on 5/20/19 at 6:22 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. The Physician's Orders, dated 4/18/18, indicated the olanzapine 7.5 mg was to be given daily at bedtime. 2. LPN 1 removed the cup of medications from		**What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Director of Nursing conducted head to toe assessment on Resident D, F, G and B. No adverse effects noted. Physician and POA notified of missed medications, medications given at the wrong time and medications not given in the correct form. Reviewed all residents' medications and administration times and based on Physician direction, made changes where applicable that was best for resident. Physician gave new order to change Resident D's medication to an evening administration. Physician gave new order for Resident F's medication to be administered in a crushed form if needed. No new orders given for Resident G and B's missed medications. **How will you identify other residents having potential to be affected by the same deficient practice?** Any resident has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?**	

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	Resident F's slot in the Medication Cart at 5:28 p.m.. The medications were compared with those still in the original containers. The medications included vitamin B-12 sublingual (under the tongue) microlozeng (supplement) 500 micrograms. LPN 1 crushed and opened the capsules of the medications and placed them in apple sauce and administered the medications to the resident. Resident F's record was reviewed on 5/20/19 at 6:30 p.m. The diagnoses included, but were not limited to, dementia. A Physician's order, dated 3/16/18, indicated B-12 sublingual microlozeng (supplement) 500 micrograms, dissolve one tablet sublingual (under the tongue) twice daily. During an interview on 5/20/19 at 7:03 p.m., LPN 1 indicated if the medication was ordered at HS, then it should not have been given at the P.M. medication pass time. She was unaware Resident F's B-12 was ordered to be given sublingually. 3. Resident B's record was reviewed on 5/20/19 at 4:55 p.m. The diagnoses included, but were not limited to dementia. A Physician's Order, dated 4/29/19, indicated rivastigmine (cognitive enhancing) 4.5 milligrams daily. The MAR (Medication Administration Record), dated 5/2019, indicated there were no initials documented to indicate the rivastigmine was administered as ordered on May 11, 12, 13, 16, and 17, 2019. There were no Progress Notes, dated May 11, 12,		Nursing staff given corrective action due to the found errors on medication pass and medication documentation. Medication variance done along with corresponding incident report. Community's "Medication Assistance" policy regarding pre-pulling medication has been removed and staff inserviced on correct procedures going forward. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Nursing and/or designee will audit all residents' charts on a daily basis to ensure that all medications, as ordered by the physician, are being initialed out. This indicating that the medication was administered correctly to the resident. The Director of Nursing and/or designee will bring the results of audits to the quarterly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to next meeting. This will continue for 6 months. Monitoring is ongoing. Director of Nursing will be observing medication passes biweekly. The Director of Nursing and/or designee will bring the results of audits to the quarterly	

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	13, 16, and 17, 2019, which indicated why the rivastigmine was not administered. During an interview on 5/21/19 at 8:49 a.m., the DON acknowledged the rivastigmine had no initials to indicate the medications had been administered as ordered by the Physician. 4. Resident G's record was reviewed on 5/20/19 at 4:51 p.m. The diagnoses included, but were not limited to dementia. Physician's Order, dated 2/10/19, indicated omeprazole (stomach acid medication), 20 milligrams daily. The MAR, dated 5/2019, indicated by a lack of initials the omeprazole was not administered as ordered on 5/20/19 during the A.M. medication administration pass. During an interview on 5/21/19 at 8:49 a.m., the DON acknowledged the omeprazole had not been signed out as given per Physician's orders. This Residential tag relates to Complaint IN00295127.		QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to the meeting. This will continue for 6 months. Monitoring is ongoing. Communities Medication Assistance policy updated by removing the option to pre-pull medications.	
R 0244 Bldg. 00	410 IAC 16.2-5-4(e)(4) Health Services - Noncompliance (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on observation, record review, and interview, the facility failed to ensure doses for only 1 scheduled medication administration pass were pre-set, related to medications prepared for both the P. M. (3 p.m. - 7 p.m.) and the HS (bedtime) medication administration at one time, for 2 of 8 residents observed during a P.M. Medication Pass. (Residents D & E)	R 0244	R244 **What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice?** Director of Nursing conducted head to toe assessment on	06/14/2019

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	Findings include: During an evening Medication Pass Observation on 5/20/19 at 5 p.m., LPN 1 indicated the medication pass times were A.M.: 5 a.m. - 11 a.m. , Midday:11 a.m. - 2 p.m., P.M.: 3 p.m. - 7 p.m., and HS (bedtime): 7 p.m. - 10 p.m. "The DON (Director of Nursing) told us we can set up medications for the shift. All medications have been set up and placed in the residents' slots in the Medication Cart." The Medication Pass Observation was completed by comparing the medications already set up to the medications still in the containers in which they were delivered to the facility. 1. On 5/20/19 at 5:09 p.m., LPN 1 removed the cup of medications in Resident D's slot in the Medication Cart and the medications were compared with the pills remaining in the original containers. LPN 1 removed a mirtazapine (antidepressant) 7.5 mg (milligram) from the medication cup and indicated the medication was scheduled for HS, then placed the medication in a different medication cup in the resident's slot of the Medication Cart. LPN 1 administered the remaining medications to the resident, which included olanzapine (antipsychotic) 7.5 mg. Resident D's record was reviewed on 5/20/19 at 6:22 p.m. The diagnoses included, but were not limited to, Alzheimer's disease with late onset dementia. Physician's Orders, dated 4/18/18, indicated mirtazapine 7.5 mg give one tablet at bedtime and olanzapine 7.5 mg give one tab daily at bedtime.		Resident D and E. No adverse effects noted. Physician and POA notified of Resident D's medications given at the wrong time. Physician gave new order to change Resident D's medication to an evening administration. Resident E's evening medications were delivered correctly. **How will you identify other residents having potential to be affected by the same deficient practice?** Any resident has the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?** Nursing staff given corrective action due to the found errors on medication pass. Medication variance done along with corresponding incident report for Resident D. Community's "Medication Assistance" policy regarding pre-pulling medication has been removed and staff inserviced on correct procedures going forward. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Nursing will be observing medication passes	

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	2. On 5/20/19 at 5:42 p.m., LPN removed a cup of medications from Resident E's medication slot. The medications were compared to the containers. The medication cup included a donepezil 5 mg (cognition medication), olanzapine (antipsychotic) 5 mg, and a trazodone (anti-anxiety) 50 mg. LPN 1 indicated the medications were scheduled for HS and placed them in a medication cup in the resident's slot of the Medication cart. Resident E's record was reviewed on 5/20/19 at 6:45 p.m. The diagnoses included, but were not limited to Alzheimer's dementia. The Physician's Orders, dated 3/27/18, indicated donepezil 5 mg daily at bedtime, olanzapine 5 mg daily at bedtime, and 3/31/18, trazodone 50 mg daily at bedtime. During an interview, on 5/21/19 at 8:49 a.m., the DON indicated medications were only to be set up for one medication pass at a time. An undated facility policy, titled, "Medication Assistance", received from the DON as current on 5/21/19 at 7:35 a.m., indicated pre-pouring of medications is allowed only directly prior to the next medication pass by the person who would be administering the medication. This Residential tag relates to Complaint IN00295127.		biweekly. The Director of Nursing and/or designee will bring the results of audits to the quarterly QA committee meeting for review and recommendations. Any recommendations made by the committee will be followed up by the Director of Nursing and results brought to the meeting. This will continue for 6 months. Monitoring is ongoing. Communities Medication Assistance policy updated by removing the option to pre-pull medications.	