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	04/23/2019

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

(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 a Post survey Revisit (PSR) to the Investigation of Complaint IN00288460 completed on 3/25/19 . Complaint IN00288460 - Not corrected Facility number: 014081 Residential census: 29 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/24/19.	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 record review and interview, the facility failed to ensure Physician's Orders were completed as ordered related to medication administration, for 2 of 3 residents reviewed for Physician's Orders. (Residents B and C) Findings include: 1. Resident B's record was reviewed on 4/23/19 at 10:25 a.m. The diagnoses included, but were not limited to, dementia.	R 0241	R241 **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 B & C. No adverse effects noted. Physician and POA notified of missed medications. No new orders from	05/10/2019

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

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	The Physician's Orders, dated 4/15/19, included, Namenda (Alzheimer's/dementia) 28 mg (milligrams) at bedtime, Pravastatin (high cholesterol) 40 mg at bedtime, Seroquel (antipsychotic) 50 mg at bedtime, and Trazodone (anti-anxiety) 100 mg at bedtime. The Medication Administration Record (MAR), dated 4/2019, indicated by a lack of initials the Namenda, Pravastatin, Seroquel, and Trazodone had not been administered as ordered at bedtime on 4/22/19. During an interview on 4/23/19 at 10:59 a.m., the Director of Nursing (DON) indicated there were no initials to indicate the medications were administered as ordered on 4/22/19. 2. Resident C's record was reviewed on 4/23/19 at 9:51 a.m. The diagnoses included, but were not limited to, stroke. The Physician's Orders, dated 3/23/19, included Metoprolol tartrate (antihypertensive) 50 mg twice a day, gabapentin (neurological pain) 400 mg three times a day, Zeasorb (powder) to abdominal folds and groin twice a day. The Physician's Orders, dated 4/18/19, included apixaban (blood thinner) 5 mg twice a day, Ferrous Sulfate (iron supplement) 325 mg daily, Lactulose 20 g (grams) per 30 ml (milliliters) twice a day, risperidone (antipsychotic) 0.25 mg twice a day, sertraline (antidepressant) 150 mg daily, and Bactrim DS (antibiotic) 800 mg-160 mg twice a day for two days. The MAR, dated 4/2019, indicated by a lack of initials the following medications were not administered on the following dates and times:		physician given due to 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?** Nursing staff in-serviced on medication administration policy and procedures. All nursing staff given education on ensuring medications are being initialed out when administered. Medication variance done along with corresponding incident report. **How will the corrective action (s) be monitored to ensure the deficient practice will not recur?** Director of Nursing and/or designee will audit residents' charts on a weekly 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 monthly	

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	The Metoprolol tartrate 50 mg was not administered on 4/21/19 and 4/22/19 in the evening and on 4/22/19 in the morning. The gabapentin 400 mg was not administered in the morning on 4/22/19, midday on 4/19/19, 4/21/19, 4/22/19, and in the evening on 4/21/19 and 4/22/19. The Zeasorb was not applied on 4/21/19 and 4/22/19 in the evening and 4/22/19 in the morning. The apixaban 5 mg, ferrous sulfated 325 mg, Lactulose 20 g/30 ml, and risperidone 0.25 mg was not administered on the evening of 4/21/19 and 4/22/19 and on the morning of 4/22/19. The sertraline 150 mg was not administered on 4/22/19 in the morning. The Bactrim DS 800 mg-160 mg was not administered on 4/20/19 in the evening. During an interview on 4/23/19 at 10:13 a.m., the DON indicated there were no initials to indicate the medications were administered as ordered on the above dated. This deficiency was cited on 3/25/19. The facility failed to implement a systemic plan of correction to prevent recurrence.		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 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.	