

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155178	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/12/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545
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F000000	<p>This survey was for the Investigation of Complaint IN00155210.</p> <p>Complaint IN00155210 - Substantiated. Federal/State deficiencies related to the allegations are cited at F-282, F-333 and F-425.</p> <p>Survey dates: September 11 & 12, 2014</p> <p>Facility number: 000094 Provider number: 155178 AIM number: 100290310</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF/NF: 109 Total: 109</p> <p>Census payor type: Medicare: 11 Medicaid: 78 Other: 20 Total: 109</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Preperation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of the deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. We respectfully submit this document as our Plan of Correction for the alleged deficiencies as outline. We respectfully request Desk Compliance .***Please note ADDENDUM to F-425 as requested 10/14/14</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000282 SS=D	<p>Quality Review completed on September 19, 2014, by Brenda Meredith, R.N.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interviews, the facility failed to ensure physician orders were followed related to obtaining and administering medications following a late afternoon admission for 1 of 3 residents reviewed for admission orders. (Resident "C")</p> <p>Finding includes:</p> <p>Record reviews for Resident "C" were completed on 09/11/14 at 2:50 p.m. Resident "C" was admitted to the facility, from an ACF (Acute Care Facility: hospital) on 08/29/14. The "Progress Notes" indicated the first entry was on 08/29/14 at 16:58 (4:58 p.m.), a Friday. The ACF's Discharge Instructions indicated the resident's "Active Problems" as Cellulitis and abscess of leg (except foot), acute anoxic encephalopathy, bacterial pneumonia,</p>	F000282	<p>It is the intent of this facility to assure qualified persons provide or arrange services for each resident in accordance with their individual written plan of care. A review and investigation into the chart of Resident "C" indicated the lines drawn through and across the area of the chart "Inpatient Medication History" were completed by the ACF staff. Resident "C" admission medication orders were transcribed from the "Medications Ordered/Recommended to be Continued" portion of the Discharge Summary, NOT from the "Inpatient Medication History" of the Discharge Summary. A review of the past thirty (30) days admissions from this ACF conducted by the Executive Director - Interim, concluded this is a routine practice of a discharging physician. Seven (7) of seven (7) charts were reviewed with no adverse findings. Six (6)</p>	10/10/2014

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	<p>chronic leg pain, acute bronchitis, chronic pain, depression, hyperlipidemia, hypertension, morbid obesity, schizophrenia, migraine, hypothyroidism, peptic ulcer disease, anemia, chronic paranoid schizophrenia, gastroparesis syndrome (slow movement of bowel), COPD (Chronic Obstructive Pulmonary Disease), GERD (Gastro-Esophageal Reflux Disease), and CAD (Coronary Artery Disease) and anxiety. Resident "C" had a PICC (Peripherally Inserted Central Catheter: a form of intravenous access that can be used for a prolonged period of time).</p> <p>The Admission orders, "MEDICATIONS ORDERED/RECOMMENDED TO BE CONTINUED" from the ACF, indicated the following: "albuterol aerosol: 2 puffs, 4 times a day [wheezing] amantadine 100 mg [milligram] 1 capsule by mouth once daily [GERD] Fioricet 2 tabs, by mouth, every 6 hours, as needed for pain ceftazidime 1000 mg IV [intravenous] piggyback, every 8 hours: stop date, 09/15/14 [antibiotic] divalproex sodium 500 mg, 1 tab [tablets] by mouth, 3 times a day [schizoaffective disorder] Aricept 10 mg, 1 tab, by mouth, bedtime [dementia]</p>		<p>of the seven (7) reviewed had this practice in place with the same discharging physician. The Admissions Coordinator spoke with the Case Manager of the ACF to discuss the implications of this practice for our facility and opportunities for improvement in this area. A system will be re-educated to assure qualified persons provide or arrange services for each resident in accordance with their individual written plan of care. A "flash" meeting attended by all disciplines will take place in the room assigned to each admission to review resident needs, admission orders, durable medical equipment needed, therapies, as well as a review of medications ordered. The results of this investigation, the discussion with the Case Manager and the areas of opportunity will be presented at the next Quality Assurance Process Improvement (QAPI) meeting. This area of opportunity will be monitored for ninety (90) days by the Director of Nursing and/or designee to assure there are no adverse outcomes from this practice. Completion date October 10, 2014 and ongoing. It is the intent of this facility to assure that sufficient staff and a medication distribution system is in place to ensure safe administration of medications without unnecessary interruptions. Furthermore, if a</p>				

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	<p>Cymbalta 30 mg, 1 cap, by mouth twice a day [depression] ferrous sulfate 325 mg, 1 tab, by mouth once a day Lasix 20 mg, by mouth, once a day [iron] Nuerontin 100 mg, 1 capsule, by mouth, twice a day at 8:00 a.m. & 2:00 p.m. [peripheral neuropathy] Neurontin 600 mg, 1 tab, by mouth, bedtime [peripheral neuropathy] levothyroxine 0.075 mg, 1 tab, by mouth, once a day [thyroid] Ativan 2 mg, 1 tab, by mouth, 3 times a day [anxiety] menthol 5 mg,, 1 tab, by mouth [gastroparesis] Singulair 10 mg, 1 tab, by mouth, every evening [allergies] multivitamin, 1 tab, by mouth, once a day [vitamin] Prilosec, 40 mg, 1 cap, by mouth, once a day [GERD] Oxycodone 30 mg, 1 tab, by mouth, every 6 hours, as needed for pain Pharmacy to Dose Vancomycin IV, Communication [antibiotic] Seroquel 100 mg, 2 tabs, by mouth, bedtime [schizo affective disorder] Carafate 1 Gm [Gram], 1 tab, by mouth, 4 times a day [gastroparesis] Imitrex 100 mg 1 tab, by mouth, as needed, 1 tab by mouth now, may repeat in 2 hours, maximum 2 pills in 24 hours [migraine]</p>		<p>dose of a scheduled medication is withheld, refused, not available, or is given at a time other than scheduled, an explanatory note will be entered into the chart. If there are two (2) or more consecutive occurrences as outlined above, the physician and family are notified. Both the notification and received response is noted in the chart. Resident admissions for the past 30 days charts, twelve (12) of twelve (12) admissions were reviewed for compliance with the above statement. No disrruption of service was noted with the exception of Resident "C". Each new admission will be reviewed during "Clinical Review Meeting" to assure all services and medications were ordered, medications were given timely per physician order(s) for the first twenty four (24) - seventy two (72) hours of admission. Licensed Nurses were re-educated to the Policies and Procedures related to: "Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy", "Medication Administration-Preperation and General Guidelines", "Automated Dispensing Machine for First Dose and Emergency Medications", "Administration Procedures for all Medications, including Oral", "Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy". The results of the</p>				

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	<p>vancomycin level reminder, miscellaneous, one time only [antibiotic] Zinc 220 mg, by mouth, once a day [wound] Ambien 10 mg 1 tab by mouth, bedtime [insomnia] "</p> <p>A printed form attached to the discharge medication list indicated: "Inpatient Medication History (active at the time of summary): Do not administer these medications until re-evaluated by a provider at the next level of care."</p> <p>Pharmacy to Dose Vancomycin...NOTES TO PATIENT: Stop date, 9/15/14-[Physician's name]-Infectious Disease...."</p> <p>The remainder of the area indicated the medications, dosages, and most recent administration time prior to transfer from the ACF. The form was noted to have lines drawn across it. There was no indication if the lines were drawn through the areas of "Inpatient Medication History" by the ACF staff or the facility staff.</p> <p>The MARs (Medication Administration Record) for 08/2014, and the Progress Notes indicated several medications were unavailable for administration on 08/29/14, 08/30/14 and 08/31/14. The documentation indicated some</p>		<p>reviews and audits mentioned above will be monitored by the Director of Nursing, or designee, for 90 days, or as needed for compliance. The results of these audits and reviews will be reported and reviewed at the QAPI meeting monthly, until compliance is 90% or greater. Completion date: October 10, 2014 and ongoing</p>		

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	<p>medications, as available, were signed out of the ADU (Automated Dispense Unit: an automated drug storage unit to enable staff to access medications, for new residents prior to the contracted pharmacy delivery of the ordered medications.) The documentation indicated some medications were signed as given by the med nurse; however, there was no record of some medications being removed from the ADU or delivered prior to the ordered medications arriving to the facility on 08/31/14 at 2:27 p.m.</p> <p>LPN #2 was interviewed on 09/12/14 at 10:20 a.m. LPN #2 indicated the resident was not to receive any Vancomycin prior to a trough level drawn on 09/02/14. LPN #2 indicated she was unaware if a staff nurse had clarified the orders with the ACF or the resident's physician.</p> <p>The Unit Manager was interviewed on 9/12/14 at 10:30 a.m. The Unit Manager indicated the admission orders were checked and entered into the computer system by herself and another nurse. The Unit manager indicated the physician was not notified to clarify the medication orders.</p> <p>On 9/12/14 at 1:10 p.m., an interview with the Interim DNS (Director Nursing</p>			

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	<p>Services), Unit Manager, and the Administrator indicated there was a discrepancy in regards to the MAR, dated 08/2014, and the ADU Medication Dispense History form. The Unit Manager clarified if the medications were signed as given and there was no record of the medications being dispensed by the ADU or prior to the pharmacy delivery, the medication would not be recognized as given.</p> <p>The documentation on the 08/2014 MAR indicated the following medications were not given as per physician's orders:</p> <p>"Ceftazidime Sodium in Dextrose solution 1/GM [Gram]/50 ML [milliliters]. Give 1 GM Intravenously every 8 hours for wound: d/c [discontinue]: 09/12/14: 08/29/14: 2200 [10:00 p.m.] 08/30/14: 0600 [6:00 a.m.] 08/30/14: 1400 [2:00 p.m.] 08/30/14: 2200 [10:00 p.m.] 08/31/14: 0600</p> <p>Amantadine [Zantac] 100 mg 1 tab by mouth in morning for Parkinson's: 08/30/14: 0900 [9:00 a.m.] 08/31/14: 0900</p> <p>Donepezil [Aricept] 10 mg 1 tab by mouth at bedtime related to dementia:</p>			

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	<p>08/29/14: 2100 [9:00 p.m.]</p> <p>Ferrous Sulfate 325 mg 1 tab by mouth in morning for anemia: 08/30/14: 0900</p> <p>Furosemide [Lasix] 20 mg 1 tab by mouth in a.m. for...heart disease: 08/30/14: 0900</p> <p>Gabapentin [Neurontin] 600 mg 1 tab by mouth at bedtime related to peripheral neuropathy: 08/29/14: 2100 08/30/14: 2100 08/31/14: 2100</p> <p>Levothyroxine [thyroid] 0.075 mg by mouth in the morning related to hypothyroidism: 08/30/14: 0600 documented as given [signed out from ADU at 5:54 p.m.: Wrong time] 08/31/14: 0600 documented as given [signed out from ADU at 4:59 p.m.: Wrong time]</p> <p>Multivitamins 1 capsule by mouth in morning, supplement: 08/30/14: 08/30/14</p> <p>Quetiapine [Seroquel] 100 mg, give 2 tabs at bedtime for schizoaffective disorder:</p>			

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	<p>08/29/14: 2100 08/30/14: 2100</p> <p>Singulair 10 mg, give 1 tab by mouth in evening for allergies: 08/29/14: 2100 08/30/14: 2100 08/31/14: 2100</p> <p>Zinc Sulfate 220 mg by mouth, 1 time a day related to closed fracture part of neck of femur: 08/30/14: 0900 08/31/14: 0900</p> <p>Duloxetine Delayed Release [Cymbalta] 30 mg, give 1 capsule by mouth 2 times a day related to depressive disorder: 08/29/14: 2100 08/30/14: 0900 08/30/14: 2100 08/31/14: 0900</p> <p>Gabapentin [Neurontin] 100 mg give capsule by mouth 2 times a day, related to peripheral neuropathy: 08/30/14: 0800</p> <p>Omeprazole [Prilosec] Delayed Release 40 mg, give 2 times a day related to Esophageal Reflux: 08/29/14: 2100 08/30/14: 0900 08/30/14: 2100</p>			

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	<p>08/31/14: 0900 08/31/14: 2100</p> <p>Divalproex Sodium [Depakote] Delayed Release, give 5000 mg by mouth 3 times a day, related to Schizophrenia: 08/29/14: 1800 [6:00 p.m.] 08/30/14: 0900 08/30/14: 1300 08/30/14: 1800 08/31/14: 0900 08/31/14: 1300 08/31/14: 1800</p> <p>Lorazepam 2 mg, give 1 tab by mouth 3 times a day for anxiety: 08/29/14: 1800 08/30/14: 0900 08/30/14: 1300 08/30/14: 1800 [noted a 0.5 mg dose signed out from the facility's ADU on 08/30/14 at 11:21 p.m. Wrong dose/Wrong time.] 08/31/14: 0900 [noted a 0.5 mg dose signed out from the facility's ADU on 08/31/14 at 11:56 a.m. Wrong dose/Wrong time] 08/31/14: 1300 [noted a 0.5 mg dose signed out from the facility's ADU on 08/31/14 at 2:15 p.m. Wrong dose/Wrong time] 08/31/14: 1800</p> <p>Metoclopramide [Reglan] 5 mg tablet by</p>			

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	<p>mouth 3 times a day related to gastroparesis & Esophageal Reflux: 08/29/14: 1800 08/30/14: 0900</p> <p>Albuterol [Proventil] Sulfate Aerosol, 2 puffs inhale orally 4 times a day, related to acute bronchitis: 08/29/14: 1700 [5:00 p.m.] 08/29/14: 2100 08/30/14: 0900 08/30/14: 1300 08/30/14: 1700 08/30/14: 2100 08/31/14: 0900 08/31/14: 1300 08/31/14: 1700 08/31/14: 2100</p> <p>Carafate 1 GM (Gram), give 1 tablet by mouth, 4 times a day, related to gastroparesis: 08/29/14: 1700 08/29/14: 2100 08/30/14: 0900 08/30/14: 1300 08/30/14: 1700 08/30/14: 2100 08/31/14: 0900 08/31/14: 1300 "</p> <p>The August 2014 MAR did not contain any reference to Vancomycin related to if the Vancomycin was to be given and not</p>			

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	<p>held. Resident "C" missed 11 doses of the IV antibiotic.</p> <p>A form, titled, "[Pharmacy name] Facility Communication Form," dated 08/31/14, indicated :</p> <p>"Other: PHARMACY RECOMMENDATION ON VANCOMYCIN DOSING: BEGIN DOSE AT 1000 MG EVERY 12 HOURS. SCHEDULE VANCOMYCIN TROUGH TO BE DRAWN 30 MINUTES PRIOR TO 4TH DOSE WHICH SHOULD BE ON 09/01/14. FAX RESULTS TO PHARMACY FOR CONTINUED DOSING RECOMMENDATIONS. THANK YOU, [Pharmacist name] 08/31/14 9:30 p.m. For any questions or comments please call: [phone number] or fax [fax number]."</p> <p>The Unit Manager was interviewed on 09/12/14 at 1:00 p.m. The Unit Manager described the events pertaining to medications for Resident "C" as follows:</p> <p>The Unit Manager indicated there was no order to give Vancomycin. The Unit Manager indicated the Vancomycin was not to be given until a trough blood level was drawn on 09/02/14. The Unit Manager did not indicate if the lines through the "Inpatient Medication</p>				

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	<p>History" were placed by the ACF staff prior to the resident admission or the facility staff when the orders were reviewed, which noted the Vancomycin was every 12 hours and the last dose was given 08/29/14 at 7:35 a.m., at the ACF. The Unit Manager indicated the facility did not contact the ACF or the resident's attending physician to clarify the order.</p> <p>In addition, the Unit Manager indicated Resident "C" was admitted to the facility "sometime late" on Friday, 08/29/14, and the facility was aware the resident had a PICC line for IV antibiotics prior to admission. The Unit Manager indicated she reviewed the orders with LPN #3 and the orders were entered into the facility's computer system, a computer generated MAR was printed, and medications for Resident "C" were ordered from the corporate pharmacy, which is located in Indianapolis. The Unit Manager indicated the orders were placed "after hours," with delivery expected on 08/30/14. The Unit Manager indicated the medications did not arrive on 08/30/14, despite repeated calls placed by LPN #3.</p> <p>The pharmacy tracking slip indicated the medications were delivered in error to another facility, in another county. The tracking slip indicted the medications</p>			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-FOUNTAINVIEW				STREET ADDRESS, CITY, STATE, ZIP CODE 609 W TANGLEWOOD LN MISHAWAKA, IN 46545			
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	<p>were delivered to the facility on 08/31/14 at 2:27 p.m.</p> <p>The DNS and Administrator were interviewed at 1:10 p.m. The DNS and Administrator indicated all medications were filled by the corporate pharmacy or through the facility's ADU.</p> <p>The Administrator provided Pharmacy Policies and Procedures on 09/12/14 at 1:20 p.m.</p> <p>The Corporate Pharmacy Policy, "[Pharmacy Name] Medication Administration - General Guidelines: 2011", indicated: "Policy:...The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions." "Procedures:...D. Documentation...5) If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time..An explanatory note is entered on the reverse side of the record. If two consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response."</p> <p>This Federal tag relates to Complaint IN00155210.</p>						

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F000333 SS=D	3.1-35(g)(2) 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interviews, the facility failed to ensure medications were available and/or administered timely following admission for 1 of 3	F000333	It is the intent of this facility to ensure medications are available and/or administered timely following admission to the facility. Residents will be free of any	10/10/2014

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	<p>residents reviewed for medication orders. (Resident "C")</p> <p>Finding includes:</p> <p>Record review for Resident "C" was completed on 09/11/14 at 2:50 p.m. Resident "C" was admitted to the facility from an ACF (Acute Care Facility: hospital) on 08/29/14. The Review of the "Progress Notes" indicated the first entry on 08/29/14 at 16:58 (4:58 p.m.), a Friday. Review of the ACF's Discharge Instructions indicated the resident's "Active Problems" included, but were not limited to, Celluitis and abscess of leg (except foot), acute anoxic encephalopathy, bacterial pneumonia, acute bronchitis and hypothyroidism.</p> <p>Review of the Admission orders, dated 08/29/14, "MEDICATIONS ORDERED/RECOMMENDED TO BE CONTINUED" from the ACF included, but were not limited to:</p> <p>ceftazidime 1000 mg IV [intravenous] piggyback, every 8 hours: stop date, 09/15/14 [antibiotic]</p> <p>levothyroxine 0.075 mg, 1 tab, by mouth, once a day [thyroid]</p> <p>Pharmacy to Dose Vancomycin IV,</p>		<p>significant medication errors. Resident admissions for the past 30 days charts, twelve (12) of twelve (12) admissions were reviewed for compliance with the above statement. No disrruption of service was noted with the exception of Resident "C". Each new admission will be reviewed during "Clinical Review Meeting" to assure all services and medications were ordered, medications were given timely per physician order(s) for the first twenty four (24) - seventy two (72) hours of admission. Licensed Nurses were re-educated to the Policies and Procedures related to: "Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy", "Medication Administration-Preparation and General Guidelines", "Automated Dispensing Machine for First Dose and Emergency Medications", "Administration Procedures for all Medications, including Oral", "Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy". The results of the reviews and audits mentioned above will be monitored by the Director of Nursing, or designee, for 90 days, or as needed for compliance. The results of these audits and reviews will be reported and reviewed at the QAPI meeting monthly, until compliance is 90% or greater. Completion</p>				

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	<p>Communication [antibiotic]</p> <p>Following the list of 25 medications, the discharge instructions indicated, with line drawn through the areas: "Inpatient Medication History (active at the time of summary): Do not administer these medications until re-evaluated by a provider at the next level of care.</p> <p>Pharmacy to Dose Vancomycin...NOTES TO PATIENT: Stop date, 9/15/14- [Physician's name]-Infectious Disease...."</p> <p>The remainder of the area indicated the medications, dosages, and most recent administration time prior to transfer from the ACF. There was no indication if the lines were drawn through the areas of "Inpatient Medication History" by the ACF staff or the facility staff.</p> <p>Review of the MARs (Medication Administration Record) for 08/2014 and the Progress Notes indicated several medications were unavailable for administration on 08/29/14, 08/30/14 and 08/31/14. The documentation indicated some medications, as available, were signed out of the ADU (Automated Dispense Unit: an automated drug storage unit to enable staff to access medications, for new residents prior to</p>		date: October 10, 2014 and ongoing	

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	<p>the contracted pharmacy delivery of the ordered medications.) The documentation indicated some medications were signed as given by the med nurse; however, there was no record of some medications being removed from the ADU or delivered prior to the ordered medications arriving to the facility on 08/31/14 at 2:27 p.m.</p> <p>On 9/12/14 at 1:10 p.m., an interview with the Interim DNS (Director Nursing Services), Unit Manager, and the Administrator, indicated if the medications were signed as given and there was no record of the medications being dispensed by the ADU or prior to the pharmacy delivery, the medication would not be recognized as given.</p> <p>The documentation on the 08/2014 MAR indicated the following medications were not given as per physician's orders:</p> <p>"Ceftazidime Sodium in Dextrose solution 1/GM [Gram]/50 ML [milliliters]. Give 1 GM Intravenously every 8 hours for wound: d/c [discontinue]: 09/12/14: 08/29/14: 2200 [10:00 p.m.] 08/30/14: 0600 [6:00 a.m.] 08/30/14: 1400 [2:00 p.m.] 08/30/14: 2200 [10:00 p.m.] 08/31/14: 0600</p>			

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	<p>Levothyroxine [thyroid] 0.075 mg by mouth in the morning related to hypothyroidism: 08/30/14: 0600 documented as given [signed out from ADU at 5:54 p.m.: wrong time] 08/31/14: 0600 documented as given [signed out from ADU at 4:59 p.m.: wrong time]</p> <p>The August 2014, MAR did not contain any reference to Vancomycin related to if the Vancomycin was to be given, and not held. Resident "C" missed 11 doses of the IV antibiotic.</p> <p>The Administrator provided several Policies and Procedures on 09/12/14 at 1:20 p.m.</p> <p>Review of the Corporate Pharmacy Policy, "[Pharmacy name] Administration - General Guidelines: 2011", indicated: "Policy:...The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions."</p> <p>This Federal tag relates to Complaint IN00155210.</p> <p>3.1-25(a)</p>			

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	<p>part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p>	F000425	<p>It is the intent of this facility to ensure medications are available for timely administration following admissions to the facility. Resident admissions for the past 30 days charts, twelve (12) of twelve (12) admissions, were reviewed for compliance with the above statement. No disruption of service was noted with the exception of Resident "C". Each new admission will be reviewed during "Clinical Review Meeting" to assure all services and medications were ordered, medications were given timely per physician order(s) for the first twenty four (24) - seventy two (72) hours of admission. 10/14/14 requested</p> <p>ADDENDUM: The pharmacy consultant will audit each new admission during regular visit, minimum of every 30 days, to ensure this deficiency does not occur. Results of these audits</p>	10/10/2014

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	<p>Based on record review and interviews, the facility failed to ensure medications were available for timely administration following a late afternoon admission for 1 of 3 residents reviewed for admission orders. (Resident "C")</p> <p>Finding includes:</p> <p>Record reviews for Resident "C" were completed on 09/11/14 at 2:50 p.m. Resident "C" was admitted to the facility, from an ACF (Acute Care Facility: hospital) on 08/29/14. The "Progress Notes" indicated the first entry was on 08/29/14 at 16:58 (4:58 p.m.), a Friday. The ACF's Discharge Instructions indicated the resident's "Active Problems" as Celluitis and abscess of leg (except foot), acute anoxic encephalopathy, bacterial pneumonia, chronic leg pain, acute bronchitis, chronic pain, depression, hyperlipidemia, hypertension, morbid obesity, schizophrenia, migraine, hypothyroidism, peptic ulcer disease, anemia, chronic paranoid schizophrenia, gastroparesis syndrome (slow movement of bowel), COPD (Chronic Obstructive Pulmonary</p>		<p>will be reviewed by the QAPI meeting monthly, until compliance is 90% or greater. Licensed Nurses were re-educated to the Policies and Procedures related to: "Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy", "Medication Administration-Preperation and General Guidelines", "Automated Dispensing Machine for First Dose and Emergency Medications", "Administration Procedures for all Medications, including Oral", "Ordering and Receiving Non-Controlled Medications from the Dispensing Pharmacy". The results of the reviews and audits mentioned above will be monitored by the Director of Nursing, or designee, for 90 days, or as needed for compliance. The results of these audits and reviews will be reported and reviewed at the QAPI meeting monthly, until compliance is 90% or greater. Completion date: October 10, 2014 and ongoing Addendum Completion date: 10. 28.14 and ongoing</p>		

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	<p>Disease), GERD (Gastro-Esophageal Reflux Disease) and CAD (Coronary Artery Disease), and anxiety. Resident "C" had a PICC (Peripherally Inserted Central Catheter: a form of intravenous access that can be used for a prolonged period of time).</p> <p>The Admission orders, "MEDICATIONS ORDERED/RECOMMENDED TO BE CONTINUED" from the ACF, indicated the following: "albuterol aerosol: 2 puffs, 4 times a day [wheezing] amantadine 100 mg [milligram] 1 capsule by mouth once daily [GERD] Fioricet 2 tabs, by mouth, every 6 hours, as needed for pain ceftazidime 1000 mg IV [intravenous] piggyback, every 8 hours: stop date, 09/15/14 [antibiotic] divalproex sodium 500 mg, 1 tab [tablets] by mouth, 3 times a day [schizoaffective disorder] Aricept 10 mg, 1 tab, by mouth, bedtime [dementia] Cymbalta 30 mg, 1 cap, by mouth twice a day [depression] ferrous sulfate 325 mg, 1 tab, by mouth once a day Lasix 20 mg, by mouth, once a day [iron] Nuerontin 100 mg, 1 capsule, by mouth, twice a day at 8:00 a.m. & 2:00 p.m. [peripheral neuropathy]</p>			

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	<p>Neurontin 600 mg, 1 tab, by mouth, bedtime [peripheral neuropathy] levothyroxine 0.075 mg, 1 tab, by mouth, once a day [thyroid] Ativan 2 mg, 1 tab, by mouth, 3 times a day [anxiety] menthol 5 mg,, 1 tab, by mouth [gastroparesis] Singulair 10 mg, 1 tab, by mouth, every evening [allergies] multivitamin, 1 tab, by mouth, once a day [vitamin] Prilosec, 40 mg, 1 cap, by mouth, once a day [GERD] Oxycodone 30 mg, 1 tab, by mouth, every 6 hours, as needed for pain Pharmacy to Dose Vancomycin IV, Communication [antibiotic] Seroquel 100 mg, 2 tabs, by mouth, bedtime [schizo affective disorder] Carafate 1 Gm [Gram], 1 tab, by mouth, 4 times a day [gastroparesis] Imitrex 100 mg 1 tab, by mouth, as needed, 1 tab by mouth now, may repeat in 2 hours, maximum 2 pills in 24 hours [migraine] vancomycin level reminder, miscellaneous, one time only [antibiotic] Zinc 220 mg, by mouth, once a day [wound] Ambien 10 mg 1 tab by mouth, bedtime [insomnia] "</p> <p>A printed form attached to the discharge</p>			

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	<p>medication list indicated: "Inpatient Medication History (active at the time of summary): Do not administer these medications until re-evaluated by a provider at the next level of care."</p> <p>Pharmacy to Dose Vancomycin...NOTES TO PATIENT: Stop date, 9/15/14-[Physician's name]-Infectious Disease...."</p> <p>The remainder of the area indicated the medications, dosages, and most recent administration time prior to transfer from the ACF. The form was noted to have lines drawn across it. There was no indication if the lines were drawn through the areas of "Inpatient Medication History" by the ACF staff or the facility staff.</p> <p>The MARs (Medication Administration Record) for 08/2014, and the Progress Notes indicated several medications were unavailable for administration on 08/29/14, 08/30/14 and 08/31/14. The documentation indicated some medications, as available, were signed out of the ADU (Automated Dispense Unit: an automated drug storage unit to enable staff to access medications, for new residents prior to the contracted pharmacy delivery of the ordered medications.) The documentation indicated some medications were signed</p>			

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	<p>as given by the med nurse; however, there was no record of some medications being removed from the ADU or delivered prior to the ordered medications arriving to the facility on 08/31/14 at 2:27 p.m.</p> <p>LPN #2 was interviewed on 09/12/14 at 10:20 a.m. LPN #2 indicated the resident was not to receive any Vancomycin prior to a trough level drawn on 09/02/14. LPN #2 indicated she was unaware if a staff nurse had clarified the orders with the ACF or the resident's physician.</p> <p>The Unit Manager was interviewed on 9/12/14 at 10:30 a.m. The Unit Manager indicated the admission orders were checked and entered into the computer system by herself and another nurse. The Unit manager indicated the physician was not notified to clarify the medication orders.</p> <p>On 9/12/14 at 1:10 p.m., an interview with the Interim DNS (Director Nursing Services), Unit Manager, and the Administrator indicated there was a discrepancy in regards to the MAR, dated 08/2014, and the ADU Medication Dispense History form. The Unit Manager clarified if the medications were signed as given and there was no record of the medications being dispensed by the</p>			

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	<p>ADU or prior to the pharmacy delivery, the medication would not be recognized as given.</p> <p>The documentation on the 08/2014 MAR indicated the following medications were not given as per physician's orders:</p> <p>"Ceftazidime Sodium in Dextrose solution 1/GM [Gram]/50 ML [milliliters]. Give 1 GM Intravenously every 8 hours for wound: d/c [discontinue]: 09/12/14: 08/29/14: 2200 [10:00 p.m.] 08/30/14: 0600 [6:00 a.m.] 08/30/14: 1400 [2:00 p.m.] 08/30/14: 2200 [10:00 p.m.] 08/31/14: 0600</p> <p>Amantadine [Zantac] 100 mg 1 tab by mouth in morning for Parkinson's: 08/30/14: 0900 [9:00 a.m.] 08/31/14: 0900</p> <p>Donepezil [Aricept] 10 mg 1 tab by mouth at bedtime related to dementia: 08/29/14: 2100 [9:00 p.m.]</p> <p>Ferrous Sulfate 325 mg 1 tab by mouth in morning for anemia: 08/30/14: 0900</p> <p>Furosemide [Lasix] 20 mg 1 tab by mouth in a.m. for...heart disease:</p>			

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	<p>08/30/14: 0900</p> <p>Gabapentin [Neurontin] 600 mg 1 tab by mouth at bedtime related to peripheral neuropathy: 08/29/14: 2100 08/30/14: 2100 08/31/14: 2100</p> <p>Levothyroxine [thyroid] 0.075 mg by mouth in the morning related to hypothyroidism: 08/30/14: 0600 documented as given [signed out from ADU at 5:54 p.m.: wrong time] 08/31/14: 0600 documented as given [signed out from ADU at 4:59 p.m.: wrong time]</p> <p>Multivitamins 1 capsule by mouth in morning, supplement: 08/30/14: 08/30/14</p> <p>Quetiapine [Seroquel] 100 mg, give 2 tabs at bedtime for schizoaffective disorder: 08/29/14: 2100 08/30/14: 2100</p> <p>Singulair 10 mg, give 1 tab by mouth in evening for allergies: 08/29/14: 2100 08/30/14: 2100 08/31/14: 2100</p>						

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	<p>Zinc Sulfate 220 mg by mouth, 1 time a day related to closed fracture part of neck of femur: 08/30/14: 0900 08/31/14: 0900</p> <p>Duloxetine Delayed Release [Cymbalta] 30 mg, give 1 capsule by mouth 2 times a day related to depressive disorder: 08/29/14: 2100 08/30/14: 0900 08/30/14: 2100 08/31/14: 0900</p> <p>Gabapentin [Neurontin] 100 mg give capsule by mouth 2 times a day, related to peripheral neuropathy: 08/30/14: 0800</p> <p>Omeprazole [Prilosec] Delayed Release 40 mg, give 2 times a day related to Esophageal Reflux: 08/29/14: 2100 08/30/14: 0900 08/30/14: 2100 08/31/14: 0900 08/31/14: 2100</p> <p>Divalproex Sodium [Depakote] Delayed Release, give 5000 mg by mouth 3 times a day, related to Schizophrenia: 08/29/14: 1800 [6:00 p.m.] 08/30/14: 0900</p>			

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	<p>08/30/14: 1300 08/30/14: 1800 08/31/14: 0900 08/31/14: 1300 08/31/14: 1800</p> <p>Lorazepam 2 mg, give 1 tab by mouth 3 times a day for anxiety: 08/29/14: 1800 08/30/14: 0900 08/30/14: 1300 08/30/14: 1800 [noted a 0.5 mg dose signed out from the facility's ADU on 08/30/14 at 11:21 p.m. Wrong dose/Wrong time.] 08/31/14: 0900 [noted a 0.5 mg dose signed out from the facility's ADU on 08/31/14 at 11:56 a.m. Wrong dose/Wrong time] 08/31/14: 1300 [noted a 0.5 mg dose signed out from the facility's ADU on 08/31/14 at 2:15 p.m. Wrong dose/Wrong time] 08/31/14: 1800</p> <p>Metoclopramide [Reglan] 5 mg tablet by mouth 3 times a day related to gastroparesis & Esophageal Reflux: 08/29/14: 1800 08/30/14: 0900</p> <p>Albuterol [Proventil] Sulfate Aerosol, 2 puffs inhale orally 4 times a day, related to acute bronchitis:</p>						

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	<p>08/29/14: 1700 [5:00 p.m.] 08/29/14: 2100 08/30/14: 0900 08/30/14: 1300 08/30/14: 1700 08/30/14: 2100 08/31/14: 0900 08/31/14: 1300 08/31/14: 1700 08/31/14: 2100</p> <p>Carafate 1 GM (Gram), give 1 tablet by mouth, 4 times a day, related to gastroparesis: 08/29/14: 1700 08/29/14: 2100 08/30/14: 0900 08/30/14: 1300 08/30/14: 1700 08/30/14: 2100 08/31/14: 0900 08/31/14: 1300 "</p> <p>The August 2014 MAR did not contain any reference to Vancomycin related to if the Vancomycin was to be given and not held. Resident "C" missed 11 doses of the IV antibiotic.</p> <p>A form, titled, "[Pharmacy name] Facility Communication Form," dated 08/31/14, indicated : "Other: PHARMACY RECOMMENDATION ON</p>						

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	<p>VANCOMYCIN DOSING: BEGIN DOSE AT 1000 MG EVERY 12 HOURS. SCHEDULE VANCOMYCIN TROUGH TO BE DRAWN 30 MINUTES PRIOR TO 4TH DOSE WHICH SHOULD BE ON 09/01/14. FAX RESULTS TO PHARMACY FOR CONTINUED DOSING RECOMMENDATIONS. THANK YOU, [Pharmacist name] 08/31/14 9:30 p.m. For any questions or comments please call: [phone number] or fax [fax number]."</p> <p>The Unit Manager was interviewed on 09/12/14 at 1:00 p.m. The Unit Manager described the events pertaining to medications for Resident "C" as follows:</p> <p>The Unit Manager indicated there was no order to give Vancomycin. The Unit Manager indicated the Vancomycin was not to be given until a trough blood level was drawn on 09/02/14. The Unit Manager did not indicate if the lines through the "Inpatient Medication History" were placed by the ACF staff prior to the resident admission or the facility staff when the orders were reviewed, which noted the Vancomycin was every 12 hours and the last dose was given 08/29/14 at 7:35 a.m., at the ACF. The Unit Manager indicated the facility did not contact the ACF or the resident's</p>			

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	<p>attending physician to clarify the order.</p> <p>In addition, the Unit Manager indicated Resident "C" was admitted to the facility "sometime late" on Friday, 08/29/14, and the facility was aware the resident had a PICC line for IV antibiotics prior to admission. The Unit Manager indicated she reviewed the orders with LPN #3 and the orders were entered into the facility's computer system, a computer generated MAR was printed, and medications for Resident "C" were ordered from the corporate pharmacy, which is located in Indianapolis. The Unit Manager indicated the orders were placed "after hours," with delivery expected on 08/30/14. The Unit Manager indicated the medications did not arrive on 08/30/14, despite repeated calls placed by LPN #3.</p> <p>The pharmacy tracking slip indicated the medications were delivered in error to another facility, in another county. The tracking slip indicted the medications were delivered to the facility on 08/31/14 at 2:27 p.m.</p> <p>The DNS and Administrator were interviewed at 1:10 p.m. The DNS and Administrator indicated all medications were filled by the corporate pharmacy or through the facility's ADU.</p>			
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	<p>The Administrator provided Pharmacy Policies and Procedures on 09/12/14 at 1:20 p.m.</p> <p>The Corporate Pharmacy Policy, "[Pharmacy Name] Medication Administration - General Guidelines: 2011," indicated: "Policy:...The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions." "Procedures:...D. Documentation...5) If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time..An explanatory note is entered on the reverse side of the record. If two consecutive doses of a vital medication are withheld, refused, or not available the physician is notified. Nursing documents the notification and physician response."</p> <p>This Federal tag relates to Complaint IN00155210.</p> <p>3.1-25(a)</p>			

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