

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155546	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/06/2013
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NAME OF PROVIDER OR SUPPLIER BETHEL POINTE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3400 W COMMUNITY DR MUNCIE, IN 47304
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F000000	<p>This visit was for the Investigation of Complaint IN00128761.</p> <p>Complaint IN00128761 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323 and F425.</p> <p>Survey dates: June 4, 5, and 6, 2013</p> <p>Facility number: 000565 Provider number: 155546 AIM number: 100267630</p> <p>Surveyor: Betty Retherford RN</p> <p>Census bed type: SNF/NF: 73 SNF: 12 Total: 85</p> <p>Census payor type: Medicare: 18 Medicaid: 50 Other: 17 Total: 85</p> <p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000	<p>The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the Plan of Correction is not an admission that deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by State and Federal law. This facility requests paper compliance for this Complaint Survey IN00128761.</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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	Qulaity Review completed by Debora Barth, RN.			

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F000323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure the nursing staff provided supervision and assistance in accordance with each resident's plan of care to prevent falls for 1 of 3 residents reviewed for falls in a sample of 7. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 6/4/13 at 2:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, Alzheimer's disease, depressive disorder, chronic pain, dementia with behavioral disturbances, pain in joints, and abnormality of gait.</p> <p>A quarterly Minimum Data Set (MDS) assessment for Resident #C, dated 3/22/13, indicated the resident was severely cognitively impaired. The assessment indicated the resident required extensive assistance of the staff for transfers and toileting. The</p>	F000323	<p>1. Resident #C's intervention not to be left alone when toileting was placed immediately following the resident's fall 3/31/13.</p> <p>2. All residents with severely impaired cognition who also require extensive assistance of the staff for transfers and toileting have the potential to be affected. An audit was completed to identify all other residents indicated per the MDS assessment with the above criteria.</p> <p>3. An inservice to be provided to nursing staff to address resident's toileting. Residents identified as extensive assistance with transfers will be deemed unsafe to leave alone while being toileted. Aide assignment sheets and care plans were updated as necessary.</p> <p>4. DON/designee to observe toileting for 2 residents daily 5 times per week for 2 weeks, then monthly on-going. Results of this audit will be forwarded monthly to QA for review.</p>	07/01/2013			

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	<p>assessment indicated the resident was not steady moving on or off of the toilet and was only able to stabilize with staff assistance.</p> <p>A fall risk assessment, dated 3/3/13, indicated the resident was at high risk for falls.</p> <p>A health care plan problem, reviewed on 3/11/13, indicated Resident "C" had multiple risk factors for falls related to unstable health conditions. One of the approaches for this problem was for the resident to be "up with assist due to weakness."</p> <p>A nursing note entry, dated 3/31/13 at 9:15 a.m., indicated the resident had been found on the floor by staff laying on her back in the threshold between her bedroom and bathroom. The note indicated the resident's right knee was bruised and she had a 10 millimeter skin tear on her left lower forearm. An assessment was done, ice was applied to the right knee, and the family and physician were notified. No orders for an emergency room evaluation were received at that time.</p> <p>A nursing note entry, dated 3/31/13 at 2:23 p.m., indicated the resident's daughter visited her at the facility and</p>				

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	<p>wanted the resident sent to the emergency room (ER) for an evaluation and x-rays. The physician was contacted and the resident was sent to the ER for an evaluation. She returned to the facility at 4:30 p.m. that day. The x-rays noted degenerative changes, but could not exclusively rule out a fracture and she was evaluated by an orthopedic physician as an outpatient on 4/4/13. No fractures were noted.</p> <p>During an interview with the DoN and Administrator on 6/5/13 at 1 p.m., additional information was requested related to the investigation of the resident's fall on 3/31/13.</p> <p>Review of an IDT (Interdisciplinary Team Note), dated 4/1/13 at 9:15 a.m., provided by the Administrator on 6/5/13 at 2 p.m., indicated the resident had been left alone in the bathroom and attempted to get up by herself and fell.</p> <p>This federal tag relates to Complaint IN00128761.</p> <p>3.1-45(a)(2)</p>				

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this 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. Based on observation, record review, and interview, the facility failed to ensure pharmacy services were provided in a manner to prevent a delay in the administration of a pain patch medication for 1 of 4 residents reviewed for pain management in a total sample of 7. (Resident #C)</p> <p>Findings include:</p> <p>During an observation with LPN #2 on 6/4/13 at 1 p.m., Resident #C was resting in bed in her room. The placement of her Fentanyl 25 mcg/hr (micrograms per hour) patch was</p>	F000425	<ol style="list-style-type: none"> Resident #Cs pain patch was applied 6/4/13. All residents receiving medicated pain patches have the potential to be affected. Rounds were completed on all other residents with orders for pain patches to ensure application per order. Sandra Hadley, RPh General Manager of Pharmacy services was immediately notified of error on 6/4/13. 1:1 education was given to nursing staff per DON 6/4/13 to alert them of the need to contact Administration immediately if 	07/01/2013			

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	<p>checked. The patch was located on her upper left shoulder. The date on the patch was 5/30/13. This indicated a time period of 5 days since the patch had been applied.</p> <p>The clinical record for Resident #C was reviewed on 6/4/13 at 2:30 p.m.</p> <p>Diagnoses for the resident included, but were not limited to, Alzheimer's disease, depressive disorder, chronic pain, dementia with behavioral disturbances, pain in joints, osteoarthritis, and abnormality of gait.</p> <p>A current physician's order, with a start date of 3/1/13, indicated Resident #C had an order for a Fentanyl Patch (a narcotic pain patch) 25 mcg/hr to be applied every three days for treatment of chronic pain.</p> <p>During an interview with the DoN on 6/4/13 at 1:30 p.m., additional information was requested related to the date of 5/30/13 on the resident's pain patch. The DoN reviewed the computerized medication administration records (MAR) and nursing notes for Resident #C and indicated the patch had not been applied because none was in supply on 6/2/13 when the nursing staff needed to change the patch. She</p>		<p>pharmacy is unable to supply pain patches. An inservice to be given to nursing staff to address appropriate procedure when re-ordering pain patches.</p> <p>4. Rochelle Englert, Pharmacy Manager will send a list of residents having outstanding or future fill scripts weekly. The DON/designee will review the list weekly with the appropriate physician to ensure timely receipt of scripts to pharmacy. DON/designee will perform audit weekly to ensure all medications having outstanding scripts were received timely. This audit to be on-going. Results of audit to be forwarded monthly to QA for review.</p>				

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	<p>indicated the pharmacy had been called on 6/2/13 (a Sunday) in regards to the patch not being in supply, but they would not authorize one to be used from the emergency supply because they needed to renew the "script" for the medication.</p> <p>During an interview with the DoN on 6/4/13 at 1:35 p.m., additional information was requested related to the nursing staff ordering the medication when the supply exhausted on 5/30/13 or had they waited until 6/2/13 to order the medication.</p> <p>During an interview with the DoN on 6/4/13 at 1:55 p.m., she indicated she had located a new supply of 10 Fentanyl pain patches for Resident #C, filled on 6/3/13, but not delivered till very late on that day. She indicated the normal time to apply the patch was 8:00 p.m., but she had instructed QMA (qualified medication aide) #3 to go ahead and apply the patch early since it had not been provided on 6/2/13.</p> <p>During an interview on 6/5/13 at 12:10 p.m., the DoN provided a copy of a "Refill Reorder Form," dated 5/28/13. The form contained the "sticker" pulled from the Fentanyl</p>			

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	<p>medication card to be used to reorder the medication. This indicated the pharmacy was notified on 5/28/13 that the resident's supply of pain patches was almost depleted. This indicated the pharmacy had a time period of 5 days from the date the medication was reordered to obtain a new "script" prior to the medication patch being needed on Sunday, 6/2/13.</p> <p>During an interview with the Administrator and DoN on 6/6/13 at 11:25 a.m., they indicated they did not know if the pharmacy had tried to get the new "script" for the pain medication prior to 6/2/13 when the nursing staff contacted them or not. They indicated the pharmacy may have waited until 6/3/13 to obtain the script and it was not delivered until very late that night. They indicated the pharmacy had not supplied the medication in a timely manner.</p> <p>This federal tag relates to Complaint IN00128761.</p> <p>3.1-25(a)</p>				