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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155166 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>04/19/2016 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>VALPARAISO CARE & REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE<br>606 WALL ST<br>VALPARAISO, IN 46383 |
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| F 0000<br><br>Bldg. 00 | <p>This visit was for the Investigation of Complaints IN00196033, IN00196379, IN00196857, and IN00198004.</p> <p>Complaint IN00196033-Substantiated. Federal/State deficiency related to the allegations is cited at F282.</p> <p>Complaint IN00196379-Substantiated. Federal/State deficiency related to the allegations is cited at F164.</p> <p>Complaint IN00196857-Substantiated. No deficiencies related to the allegation were cited.</p> <p>Complaint IN00198004- Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency is cited.</p> <p>Survey Dates: April 17, 18, and 19, 2016</p> <p>Facility number: 000083<br/>Provider number: 155166<br/>AIM number: 100289670</p> <p>Census bed type:<br/>SNF/NF: 129<br/>Total: 129</p> | F 0000 | <p><b>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></p> <p><b>Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after May 19, 2016.</b></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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| F 0164<br>SS=D<br>Bldg. 00 | <p>Census payor type:<br/>Medicare: 17<br/>Medicaid: 99<br/>Other: 13<br/>Total: 129</p> <p>Sample: 13<br/>Supplemental sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 32883 on 4/21/16.</p> <p>483.10(e), 483.75(l)(4)<br/>PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br/>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone</p> |               |   |                      |

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|  | <p>communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on record review and interview, the facility failed to ensure residents' personal information was secure and not accessible to visitors and residents of the facility, based on a visitor providing copies of medication labels, which included the names of residents, medications names, and diagnoses, for 2 residents in a sample of 13 (Residents #E and #H) and 2 residents in a supplemental sample of 3. (Residents #R and #S)</p> <p>Finding includes:</p> | F 0164  | <p><b>F164 – Personal/Privacy/Confidentiality of Records</b></p> <p>It is the practice of this provider that each resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident's #E, #H, #R and #S personal information has been kept secure and not accessible to</p> | 05/19/2016           |   |

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|  | <p>A family member/visitor informed and provided the Indiana State Department of Health with copies of resident medication labels on 03/24/16, which he indicated he had found in his family member's room at the facility.</p> <p>The labels indicated resident names, diagnoses, and medication names for Residents #E, #H, and #R.</p> <p>During a telephone a telephone interview on 04/17/16 at 6:15 p.m., the family member indicated the day the labels were found, he had put them in his pocket and was going to inform the facility, then became distracted and forgot to tell someone at the facility. He indicated he wore the coat with the labels in the pocket and remembered he had them. The family member indicated the facility was unaware of the labels being left in the resident's room and he was unsure how long ago he had found the labels. The family member waived confidentiality of the information.</p> <p>Review of the labels indicated:</p> <p>Resident #E's label was for lorazepam 0.5 mg (milligram) (anti-anxiety) 1/2 tablet every eight hours for anxiety and was delivered to the facility on 02/02/16.</p> |   | <p>visitors and other residents of the facility. The residents experienced no negative outcome as a result of this finding.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All residents have the potential to be affected by this finding. All facility medication carts, treatment carts, nurse's stations, common areas and resident rooms were inspected to ensure any residents' personal information was not accessible to visitors and residents of the facility. Rounds are completed every shift by DNS/Charge Nurse/designee to ensure resident personal information is secure and not accessible to visitors and other residents. These Rounds will ensure that resident specific information such as medication labels are stored appropriately in secure containers and that confidentiality of all resident information is maintained and safeguarded.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>A mandatory staff in-service will be conducted by the ED/DNS on</p> |                      |   |

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|                    | <p>Resident #H's label was for pentoxifylline 400 mg (leg cramps) three times a day for peripheral vascular disease and was delivered to the facility on 12/30/16.</p> <p>Resident #H's second label was for fiber-lax (laxative) one tablet twice a day for constipation and was delivered to the facility on 01/23/16.</p> <p>Resident #R's label was for furosemide 20 mg (diuretic), one tablet daily for edema, and was delivered to the facility on 12/21/15.</p> <p>Resident #S's label was for hydrocodone/acetaminophen (narcotic pain medication) 7.5/325 mg take as needed every six hours and was delivered to the facility on 02/02/16</p> <p>During an interview on 04/19/16 at 9:26 a.m., the DON (Director of Nursing) indicated when medication cards are empty, the Nurses' were to tear the top off with the resident's information on the label and take the label to the shredder located at the Nurses' Station. She indicated if the medication needed re-ordered then the label could be placed on top of the cart and turned over to hide the label and if the nurses walked away from the cart they were to take the labels</p> |               | <p>or before 5/19/16. This in-service will include review of the policy related to resident rights and privacy and confidentiality of all resident information. This in-service will also review the policy related to proper disposal and destruction of resident medication cards and labels or any document containing resident personal information. Nursing Rounds are completed every shift by DNS/Charge Nurse/designee to ensure resident personal information is secure and not accessible to visitors and other residents.</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></p> <p>Compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completion of the CQI Audit tool titled, "Medical Records" no less than 5 times per week for 3 weeks on all shifts and then monthly on all shifts for 6 months. This Audit will ensure that resident specific information such as medication labels are stored appropriately in secure containers and that confidentiality of all resident information is maintained and safeguarded. If threshold of 90% is not met, an action plan will be developed. Findings will be</p> |                      |

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| F 0282<br>SS=D   | <p>with them. She indicated there had been no privacy concerns voiced to her about the medication labels and was unsure how the visitor obtained the labels.</p> <p>During an interview on 04/19/16 at 11:04 a.m., the Administrator indicated she was unaware of labels being left in a resident's room.</p> <p>A facility policy, dated 02/2014, received as current from the Staff Development Coordinator, titled, "Medication Administration", indicated, "...6.0 When the med (medication) caret (sic) is unattended the nurse or facility staff is (sic) to lock the cart and ensure all protected health information is protected as required by the State and Federal law..."</p> <p>This Federal Tag relates to complaint IN00196379.</p> <p>3.1-3(o)</p> <p>483.20(k)(3)(ii)<br/>SERVICES BY QUALIFIED PERSONS/PER</p> |   | <p>submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic changes will be completed:</b></p> <p>Compliance date = 5/19/16.</p> |                      |   |

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| Bldg. 00 | <p><b>CARE PLAN</b><br/>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow Physician Orders related to the administration of medications timely to a newly admitted resident of the facility for 1 of 3 residents reviewed for Physician's Orders in a total sample of 13. (Resident #L)</p> <p>Finding includes:</p> <p>Resident #L's record was reviewed on 04/19/16 at 9:26 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, convulsions, gastro reflux disease, hypothyroidism, lung cancer, chronic obstructive airway, and hypertension.</p> <p>A Nursing Admission Assessment, dated 04/01/16 at 7 p.m., indicated the resident was admitted from the hospital.</p> <p>The Hospital Discharge Orders, dated 04/01/16 at 5:33 p.m., included the following Physician Medication Orders:</p> <p>Aspart Insulin (Novolog) to be given by sliding scale (amount of insulin based on blood sugar result), before meals and at bedtime and next dose was due at 10 p.m.</p> | F 0282 | <p><b>F282 – Services by Qualified Persons/Per Care Plan</b></p> <p>It is the practice of this provider that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b></p> <p>Resident # L – physician and family has been informed of resident's current medication regimen. Resident #L has been receiving medications per physician's order. Resident #L experienced no negative outcome related to this finding.</p> <p><b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b></p> <p>All newly admitted/re-admitted residents have the potential to be affected by this finding. A facility audit will be conducted by the DNS/Nurse Management Team.</p> | 05/19/2016 |
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|                    | <p>levetiracetam (seizure medication) 500 mg (milligrams), 1/2 tablet (250 mg) twice a day and next dose was due at 9 p.m.</p> <p>pantoprazole (gastro reflux medication) 40 mg, daily before breakfast and next dose was on 04/02/16 in the a.m.</p> <p>levothyroxin (hypothyroid medication) 100 mcg (microgram) daily and the next dose was on 04/02/16 in the a.m.</p> <p>metformin (for blood sugar) 500 mg, twice daily and next dose was at 9 p.m.</p> <p>metoprolol (blood pressure) 25 mg, twice a day and next dose was at 9 p.m.</p> <p>dexamethasone (breathing medication) 6 mg, give 1/2 tablet (3 mg) four times daily and next dose was 9 p.m.</p> <p>simvastatin (cholesterol medication), 2.5 mg tablet at bedtime and next dose was 9 p.m.</p> <p>The Medication Administration Record (MAR), dated 04/2016, indicated the following medications were initiated on the following dates and times:</p> <p>Humalog insulin (substitute for Novolog)</p> |               | <p>This audit will include review of all newly admitted/re-admitted Resident Transfer Medication Orders. These Transfer Orders will be reviewed and compared to the MAR to ensure that all newly admitted/re-admitted residents have been receiving medications timely and per physician order. Any medication discrepancies/concerns noted during this audit will be clarified and corrected at the time noted.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b></p> <p>A mandatory nursing in-service will be conducted on or before 5/19/16 by the DNS/designee. This in-service will include review of the facility policy related to the admission/re-admission of a resident. All nursing staff will be re-educated on the process of clarifying admission/re-admission medication orders as well as ordering, obtaining and administering medications timely per physician's order. In addition, the DNS and/or member of the Nurse Management Team will be responsible for assisting with review of all new admission/re-admission physicians orders at the time of admission. All newly admitted/re-admitted resident's</p> |                      |

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|                    | <p>was initiated on 04/02/16 at 6 a.m.</p> <p>levetiracetam 250 mg was initiated on 04/02/16 at 9 a.m.</p> <p>pantoprazole 40 mg was initiated on 04/03/16 at 6 a.m.</p> <p>levothyroxine 100 mcg was initiated on 04/03/16 at 6 a.m.</p> <p>metformin 500 mg was initiated on 04/02/16 at 9 a.m.</p> <p>metoprolol 25 mg was initiated on 04/02/16 at 9 a.m.</p> <p>dexamethasone 3 mg was initiated on 04/02/16 at 12 p.m.</p> <p>simvastatin 2.5 mg was initiated on 04/02/16 at 9 p.m.</p> <p>The Emergency Drug Kit Inventory Summary, indicated the Humalog insulin, levetiracetam 250 mg, pantoprazole 40 mg, levothyroxine 100 mcg, and metformin 500 mg was available for use in the Emergency Drug Kit.</p> <p>During an interview on 04/19/16 at 11:55 a.m., the DON (Director of Nursing) indicated if medication was not available in the Emergency Drug Kit, the Nurse</p> |               | <p>medications will be ordered through the pharmacy and available for administration to ensure all residents receive their medications timely and as ordered. The DNS/designee will be responsible for checking to be sure medications for newly admitted/re-admitted residents are received timely from the pharmacy and administered as ordered.</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></p> <p>Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completion of the CQI Audit tool titled, "Admission/Re-admission Review" no less than daily for 3 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up.</p> <p><b>By what date the systemic changes will be completed:</b></p> <p>Compliance date = 5/19/16.</p> |                      |

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|                    | <p>was to call the Pharmacy to receive the medications from the back up pharmacy or get an order from the Physician to hold the medication until the medication was available. She indicated the medications which were available in the Emergency Drug Kit (EDK) should have been given.</p> <p>A facility policy, dated 02/2014, and received as current from the DON, titled, "Backup Pharmacy", indicated, "...Only a pharmacist...may call orders into a backup pharmacy...Please contact the pharmacy if you feel this service is needed..."</p> <p>A facility policy, dated 02/2014, and received as current from the DON, titled, "Stats (immediately)", indicated, "...The pharmacy will STAT (immediately) medication orders when essential medications are required prior to the next scheduled delivery if the use of a local backup pharmacy or the EDK..is not possible...Essential medications may include, but are not limited to:...cardiac medications, and 2.4. New Resident Admissions."</p> <p>This Federal Tag relates to complaint IN00196033.</p> <p>3.1-35(g)(2)</p> |               |   |                      |

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| F 0333<br>SS=D<br>Bldg. 00 | <p>483.25(m)(2)<br/>RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure a resident was free of a significant medication error, related to an incorrect dose of Coumadin (blood thinner) prepared for administration to a resident for 1 of 11 residents observed during the medication pass observation. (Resident #Q)</p> <p>Finding includes:</p> <p>During a medication pass observation on 04/17/16 at 5:09 p.m. (Sunday), LPN #1 prepared Resident #Q's 5 p.m. medications, which included Coumadin 4 mg (milligrams). LPN #1 placed the Coumadin 4 mg in the medication cup for the resident's medication administration. The medication card label indicated the Coumadin 4 mg was ordered to be given on Monday, Wednesday, and Friday.</p> <p>LPN #1 then indicated she was finished with preparing Resident #Q's medication</p> | F 0333        | <p><b>F333 – Residents Free of Significant Med Errors</b> It is the practice of this provider to ensure that residents are free of any significant medication errors. <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</b> Resident #Q – has been receiving her medications per physician's order and experienced no negative outcome as a result of this finding. <b>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:</b> All residents have the potential to be affected by this finding. A facility audit will be conducted by the DNS/Nurse Management Team. This audit will include review of all resident Medication/Physician Orders. These Medication/Physician Orders will be reviewed and compared to the Medication Administration Record to ensure that residents have been receiving medications at</p> | 05/19/2016           |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155166 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <u>00</u><br>B. WING _____          |  | X3) DATE SURVEY COMPLETED<br><br>04/19/2016 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>VALPARAISO CARE & REHABILITATION |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>606 WALL ST<br>VALPARAISO, IN 46383 |  |   |  |
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|  | <p>and was ready to administer the medications to the resident. LPN #1 was stopped prior to the administration of the medication and LPN #1 re-read the Coumadin 4 mg label on the medication card.</p> <p>LPN #1 indicated the Coumadin 4 mg was the incorrect dose and the Physician's order was to give Coumadin 3 mg.</p> <p>Resident #Q's record was reviewed on 04/19/16 at 9:34 a.m. The resident's diagnoses included but were not limited to, stroke and atrial fibrillation.</p> <p>The Physician's Orders, dated 04/13/16, indicated Coumadin 3 mg daily on Sunday, Tuesday, Thursday, and Saturday at 5 p.m. and Coumadin 4 mg daily on Monday, Wednesday, and Friday at 5 p.m.</p> <p>A facility policy, dated 02/2014, received as current from the Staff Development Coordinator, titled, "Medication Administration", indicated, "...2.0 The Nurse is to confirm the resident ID (identification) and the prescriber order. 3.0 The Nurse should check the medication(s) three (3) times with the MAR (Medication Administration Record) in order to verify the order with the label..."</p> |   | <p>correct dosages per physician order. Any medication discrepancies/concerns noted during this audit will be clarified and corrected at the time noted. In addition, the DNS/CEC and/or designee will be responsible for validating and verifying that each licensed nurse has successfully completed a Medication Pass Observation. This will ensure that proper procedure and protocol are followed during each medication preparation and pass.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</b> A mandatory nursing in-service will be conducted on or before 5/19/16 by the DNS/designee. This in-service will include review of the facility policy related to proper procedure and best practices during medication preparation and pass including carefully ensuring proper dosages are administered per physician's order. All nursing staff will be re-educated on the process of administering medications per physician's order following best practices to reduce the possibility of a medication error. In addition, the DNS/CEC and/or designee will be responsible for validating and verifying that each licensed nurse has successfully completed a Medication Pass Observation. This will ensure that proper procedure and protocol are</p> |  |  |   |  |

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| NAME OF PROVIDER OR SUPPLIER<br><br>VALPARAISO CARE & REHABILITATION |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>606 WALL ST<br>VALPARAISO, IN 46383   |                      |   |
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|  | 3.1-48(c)(2)   |   | followed during each medication preparation and pass. <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> Ongoing compliance with this corrective action will be monitored through the facility CQI program. The DNS/designee will be responsible for completion of the CQI Audit tool titled, "Medication Pass Observation" no less than 5 times per week for 3 weeks and then monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. <b>By what date the systemic changes will be completed:</b> Compliance date = 5/19/16. |                      |   |