

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155759	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/12/2014
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NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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F000000	<p>This visit was for the Investigation of Complaint IN00142911 and Complaint IN00143153.</p> <p>Complaint IN00142911- Substantiated. Federal/State deficiency related to the allegations is cited at F425.</p> <p>Complaint IN00143153 - Substantiated. Federal/State deficiency related to the allegations is cited at F315.</p> <p>Survey dates: February 10, 11 and 12, 2014</p> <p>Facility number: 011187 Provider number: 155759 AIM number: 200838150</p> <p>Survey team: Penny Marlatt, RN, TC</p> <p>Census bed type: SNF: 25 SNF/NF: 26 Residential: 33 Total: 84</p> <p>Census payor type: Medicare: 22 Medicaid: 20</p>	F000000	<p>Submission of this plan of correction does not constitute an admission by Glen OaksHealth Campus of any wrong-doing or failure to comply with Federal or Stateregulations. Moreover, the allegations contained in this statement of deficiency arenot a true or accurate portrayal of the provision of nursing care or the services of thisfacility. The provider wishes this plan of correction be considered as our allegation ofcompliance. The provider respectfully requests a desk review with paper compliancebe considered in establishing the provider is in substantial compliance.</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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F000315 SS=D	<p>Other: 42 Total: 84</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on Febuary 17, 2014, by Janelyn Kulik, RN.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on interview, observation and record review, the facility failed to ensure 1 of 3 residents admitted with urinary catheters had documented diagnoses or reasons for the continued use of a urinary catheter and 2 of 3 residents admitted with urinary catheters had appropriate physician orders for the</p>	F000315	F 315 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:Resident B was discharged prior to 2/10/2014. The catheter for Resident C was discontinued 2/11/2014.Identification of other residents having the potential to be affected by the same alleged	03/14/2014	

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	<p>use and care associated with the urinary catheters for 3 residents reviewed for urinary catheters in a total sample of 6. (Resident #B and #C)</p> <p>Findings include:</p> <p>1. On 2-11-14 at 5:05 a.m., Resident #C was observed lying in bed. Her urinary catheter tubing was observed to be draining clear amber urine.</p> <p>Resident #C's clinical record was reviewed on 2-11-14 at 6:30 a.m. Resident #C was re-admitted to the facility on 2-4-14 with diagnoses that included, but were not limited to, urinary tract infection (UTI), acute renal failure due to sepsis, Clostridium difficile (C-diff), diverticulitis and cholelithiasis.</p> <p>Review of Resident #C's admitting orders through date of review, 2-11-14 at 6:30 a.m., there were no physician orders to address the use of the urinary catheter or its care.</p> <p>The "Nursing Admission Assessment& Data Collection," dated 2-4-14, indicated the resident had a urinary catheter present. The initial nursing care plan indicated the</p>		<p>deficient practice and corrective actions taken: All residents with urinary catheter will be reviewed to ensure medical justification / diagnosis for catheter use is in place. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate licensed nurses on requirement for obtaining medical justification from the resident's MD for the use of urinary catheters. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for all residents with catheters will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: review of all residents with urinary catheter in place to ensure medical justification / documentation is in place for the use of a urinary catheter. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation</p>		

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	<p>nursing staff were to provide catheter care each shift, observe the urinary output each shift, ensure a supporting diagnosis for catheter use and observe for signs and symptoms of a UTI.</p> <p>In an interview with the Director of Health Services (DHS) on 2-11-14 at 7:09 a.m., she indicated the resident had been re-admitted to the facility with the urinary catheter. She indicated the catheter had been ordered while the resident was at the hospital for renal failure and to monitor the urinary output. She indicated she could not find any hospital discharge orders for the use of the urinary catheter. She indicated the facility would normally try to get a urinary catheter discontinued if there was not a need for it.</p> <p>In an interview with the DHS on 2-11-14 at 11:00 a.m., she indicated the facility had obtained orders from the nurse practitioner to discontinue the use of the urinary catheter.</p> <p>2. Resident #B's clinical record was reviewed on 2-11-14 at 7:40 a.m. Resident #B was admitted to the facility on 12-13-13 as an emergency admission. Her</p>						

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	<p>diagnoses included, but were not limited to, advanced Parkinson's disease, dementia, neurogenic bladder, weakness/debility, history of chronic, frequent urinary tract infections (UTI) and a history of hip fracture.</p> <p>Review of Resident #B's physician orders from admission on 12-13-13 through discharge on 12-21-13 included only orders to check urine color and clarity each shift and provide catheter care each shift.</p> <p>The "Nursing Admission Assessment & Data Collection," dated 12-13-13, indicated the resident had a urinary catheter present. The initial nursing care plan indicated the nursing staff were to provide catheter care each shift. The initial nursing care plan did not include any additional information related to the care of the urinary catheter. The physician orders did not include any parameters for what type or size of urinary catheter should be utilized, when the catheter should be changed, nor if it required any flushing or irrigation.</p> <p>In an interview with a family member of Resident #B on 2-10-14 at 10:47 a.m., he indicated the resident had a</p>			

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	<p>urinary catheter placed approximately 3 or 4 months previously while at home. He indicated the catheter was flushed 3 times daily due to a large amount of sediment while at home. He indicated the Home Health nurse changed the urinary catheter approximately every 2 weeks. He indicated one of the reasons the family moved Resident #B to another facility after a week at this facility included lack of care for the catheter.</p> <p>This Federal tag relates to Complaint IN00143153.</p> <p>3.1-41(a)(1)</p>				

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F000425 SS=E	<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 interview and record review, the facility failed to ensure 3 of 3 residents reviewed for medications in a total sample of 6 had medications received and administered in a timely manner upon admission, including a medication available from the emergency drug kit (EDK) that was not utilized and failed to seek clarification orders for similar sounding medications and for antibiotic medications that typically have specific discontinuation dates. (Resident #A, #B, #C)</p>	F000425	F 425 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident A was discharged prior to 2/10/2014. Resident B was discharged prior to 2/10/2014. A medication stop date was obtained for Resident C on 2/11/2014. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents current orders will be reviewed to ensure medications are available. Measures put in place and systemic changes made to ensure the alleged deficient	03/14/2014			

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	<p>Findings include:</p> <p>1. Resident #A's clinical record was reviewed on 2-10-14 at 2:20 p.m. Her diagnoses included, but were not limited to, history of falls at home, Parkinson's disease, atrial fibrillation, COPD (chronic obstructive pulmonary disease), diabetes, coronary artery disease and history of stroke. It indicated she was an emergency admission to the facility on 12-27-13 at 5:00 p.m.</p> <p>In an interview with a family member on 2-10-14 at 11:23 a.m., she indicated Resident #A was an emergency admission to the facility on 12-27-13 around 5:00 p.m. She indicated the admitting nurse reviewed the resident's medications with her. She indicated she asked the admitting nurse if she needed to bring any medications in that evening, but was told by the admitting nurse that all of the resident's medications would be available by the time they were due to be given. She indicated she received a phone call the following day around 2:00 p.m. from the resident indicating she had not received any of her medication, including any insulin.</p>		<p>practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Medication Ordering and Receiving, Prescriber Medication Orders, and Emergency Pharmacy Service and Pharmacy Kits. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: medications have been ordered and are available The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>In an interview with LPN #1 on 2-10-14 at 2:35 p.m., he indicated he worked with Resident #A on 12-28-13. He indicated he was made aware of the lack of medications from the back up pharmacy for Resident #A between 7:00 am and 8:00 a.m. He indicated he contacted the consulting pharmacy at this time to check on expected arrival time. He indicated he phoned the consulting pharmacy at least 2 more times and estimated the resident's medications arrived around noon.</p> <p>An interview LPN #2 on 2-10-14 at 4:10 p.m., indicated she worked with Resident #A on 12-28-13. She indicated there had been an issue in regards to receiving Resident #A's medications from the consulting pharmacy. She indicated she contacted the consulting pharmacy between 6:15 a.m. and 6:30 a.m. She indicated she was told the medications "would get there." She indicated the medications had not arrived by 10:00 a.m. and were still not delivered by noon. She indicated calls were placed around 10:00 a.m. by herself and at noon by LPN #1 to the consulting pharmacy. She indicated the medications did arrive shortly after 2:00 p.m. She</p>			

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	<p>indicated until that time, she was able to only administer the medications that were available from the EDK. She indicated that she did discuss the issue of the late medication delivery with Resident #A's daughter "and she seemed okay with it."</p> <p>An interview with a pharmacist from the consulting pharmacy on 2-11-14 at 11:05 a.m., indicated there had been a problem with the initial delivery of the medications for Resident #A. He indicated the pharmacy had received an initial fax from the facility on 12-27-13 at 7:55 p.m. with Resident #A's initial medication orders. He indicated since the fax was received after the 5:00 p.m. deadline for medication deliveries that same date, the medications would not be sent out until the following day's delivery unless a phone call was received to request delivery be provided sooner. He indicated the pharmacy did not receive this call for a sooner delivery time until 6:30 a.m. on 12-28-13. He indicated the consulting pharmacy then contacted one of the area back up pharmacies to request availability of the medications and expected time of preparation in order for the courier service to pick up the</p>						

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	<p>medication for delivery. He indicated the back up pharmacy expected to have the medications ready for pick up around 9:30 a.m. or 10:00 a.m. as the back up pharmacy was very busy. He indicated the courier service was notified with this information, but later discovered the courier service "had acknowledged our call, but then went back to sleep. It's just a situation that had one problem and it just got worse." He indicated the consulting pharmacy's goal for delivery of medications as a "stat" (immediate or as soon as possible) or from a back up pharmacy is generally 2 hours from the time a facility calls requesting delivery until it is received by the facility. He indicated his records indicated the medications for Resident #A were received by the facility on 12-28-13 at 2:10 p.m., approximately 7.5 hours after the facility had called the consulting pharmacy to request delivery.</p> <p>Review of the physician-ordered medications indicated the following medications were received on 12-28-13 at approximately 2:10 p.m. from the courier service: -Sinemet CR 50/100 milligrams (mg) twice daily by mouth.</p>			

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	<p>-Allopurinol 100 mg daily at bedtime by mouth.</p> <p>-Valium 2 mg three times daily by mouth.</p> <p>-Cardia XT 240 mg once daily by mouth.</p> <p>-Advair Diskus 250/50 one puff twice daily by mouth.</p> <p>-Imdur 30 mg once daily by mouth.</p> <p>-Albuterol sulfate 2.5 mg/0.5 milliliters (ml), inhale 0.5 ml by nebulizer three times daily by mouth.</p> <p>-Mag Oxide 400 mg daily by mouth.</p> <p>-Lantus Insulin 10 units subcutaneously daily at bedtime.</p> <p>-Metformin 500 mg daily by mouth.</p> <p>The following physician-ordered medications were available from the EDK for immediate use:</p> <p>-Lasix 40 mg twice daily by mouth.</p> <p>-gabopentin 300 mg three times daily by mouth.</p> <p>-potassium chloride 10 milliequivalents daily by mouth.</p> <p>-simvastatin 20 mg daily by mouth.</p> <p>-warfarin 6 mg daily by mouth on Saturday, Tuesday and Thursday.</p> <p>-warfarin 3 mg daily by mouth on Sunday, Monday, Wednesday and Friday.</p> <p>-Albuterol Inhaler 2 puffs every 4 hours as needed.</p> <p>-DuoNeb via nebulizer every 6 hours as needed.</p>			

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	<p>-Norco 7.5/325 mg one tablet every 6 hours as needed.</p> <p>-Lantus Insulin 10 units subcutaneously daily at bedtime.</p> <p>The following medication was available in the EDK, but was not administered at the bedtime dose on 12-27-13:</p> <p>-Lantus Insulin 10 units subcutaneously daily at bedtime.</p> <p>2. Resident #C's clinical record was reviewed on 2-11-14 at 6:30 a.m. Resident #C was re-admitted to the facility on 2-4-14 with diagnoses that included, but were not limited to, urinary tract infection (UTI), acute renal failure due to sepsis, Clostridium difficile (C-diff), diverticulitis and cholelithiasis.</p> <p>In review of Resident #C's physician orders for medications, the following antibiotics were ordered for C-diff: Flagyl 500 milligrams (mg) three times daily by mouth and Vancomycin 250 mg, 2 tablets (total of 500 mg) four times daily by mouth. The physician orders did not include a stop or discontinuation date for the use of the antibiotics.</p> <p>In an interview with the Director of Health Services (DHS) on 2-11-14 at</p>			

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	<p>10:45 a.m., she indicated she would check on stop dates for these two medications. In an interview with the DHS on 2-11-14 at 11:00 a.m., she indicated the nurse practitioner had provided stop dates for these two medications when the current supply ran out in the next day or two.</p> <p>3. Resident #B's clinical record was reviewed on 2-11-14 at 7:40 a.m. Resident #B was admitted to the facility on 12-13-13 as an emergency admission. Her diagnoses included, but were not limited to, advanced Parkinson's disease, dementia, neurogenic bladder, weakness/debility, history of chronic, frequent urinary tract infections (UTI) and a history of hip fracture.</p> <p>Review of Resident #B's physician orders for medications upon admission included but were not limited to, Namenda 7 milligrams (mg) daily by mouth for 5 days, then Namenda 14 mg daily for 7 days, then Namenda 21 mg daily for 7 days, then Namenda 28 mg daily by mouth.</p> <p>In review of a progress note from Resident #B's neurologist, dated 12-10-13, it indicated he was going</p>			

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	<p>to restart Namenda XR at 7 mg daily and gradually increase it up to 28 mg daily. It indicated the neurologist provided a "titration pack" for this medication for the resident.</p> <p>In an interview with the Corporate Nurse and the Director of Health Services (DHS) on 2-12-14 at 2:00 p.m., the Corporate Nurse indicated the neurologist had provided the resident a titration pack for the Namenda. She indicated Namenda is available in 5 mg and 10 mg strengths. She indicated the Namenda XR is available in 7 mg, 14 mg, 21 mg, and 28 mg strengths. She indicated the nursing staff had administered the correct strength of the medication. The DHS indicated the package had the correct labeling. When queried as to if a clarification order for the medication should have been obtained during the week the resident was at the facility, the DHS indicated it probably should have been done.</p> <p>On 2-12-14 at 11:20 a.m., the Medical Records staff person provided a copy of a policy entitled, "Emergency Pharmacy Service and Emergency Kits." This policy indicated, "Emergency pharmacy services is available on a 24-hour</p>			

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NAME OF PROVIDER OR SUPPLIER GLEN OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 601 W CR 200 S NEW CASTLE, IN 47362
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	<p>basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy."</p> <p>On 2-12-14 at 11:20 a.m., the Medical Records staff person provided a copy of a policy entitled, "Ordering and Receiving Medications From the Dispensing Pharmacy." This policy indicated, "New medications, EXCEPT for emergency or 'stat' medications are ordered as follows:</p> <p>a. If needed before the next delivery time, phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within 4 hours.</p> <p>b. Timely delivery of new orders is required to that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy delivery."</p> <p>On 2-12-14 at 11:20 a.m., the Medical Records staff person provided a copy of a policy entitled, "Prescriber Medication Orders." This policy indicated, "Medications are administered only upon the clear, complete, and signed order of</p>			

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	<p>a person lawfully authorized to prescribe...</p> <p>A. Elements of the Medication Order: 1) Medications orders specify the following: <ul style="list-style-type: none"> a. Name of medication b. Strength of medication, where indicated c. Dose and dosage form d. Time or frequency of administration e. Route of administration f. Quantity of duration (length) of therapy. If not specified by the prescriber on a new order, the duration is limited by automatic stop order policy when applicable. g. Diagnosis or indication for use... </p> <p>B. Any dose or order that appears inappropriate...is verified with the attending physician.</p> <p>C. The prescriber is contacted to verify or clarify an order (e.g., when the resident has allergies to the medication, there are contraindications to the medication, the directions are confusing or delivery of medication will be delayed beyond regularly scheduled delivery."</p> <p>This Federal tag relates to Complaint IN00142911.</p>				

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	3.1-25(b) 3.1-25(g)(2)			