

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155572	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/06/2014
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NAME OF PROVIDER OR SUPPLIER  APERION CARE DEMOTTE	STREET ADDRESS, CITY, STATE, ZIP CODE 10352 N 600 E COUNTY LINE RD DEMOTTE, IN 46310
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F000000	<p>This visit was for the Investigation of Complaint IN00158562.</p> <p>Complaint IN00158562-Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F333, F371, and F425.</p> <p>Survey Dates: November 5 and 6, 2014</p> <p>Facility number: 000471 Provider number: 155572 AIM number: 100290390</p> <p>Survey team: Regina Sanders RN, TC</p> <p>Census bed type: SNF/NF: 63 Residential: 06 Total: 69</p> <p>Census payor type: Medicare: 13 Medicaid: 37 Other: 13 Total: 63</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC</p>	F000000		

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>16.2-3.1.</p> <p>Quality review completed on November 10, 2014, by Janelyn Kulik, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 observation, record review and interview, the facility failed to ensure residents' Physicians' Orders and care plans were followed, related to medications and treatments, for 3 of 9 residents reviewed for Physicians' Orders and care plans in a total sample of 9. (Residents #E, #G, and #H)</p> <p>Findings include:</p> <p>1. Resident #H's record was reviewed on 11/05/14 at 2 p.m. The resident's diagnoses included, but were not limited to, stroke, hypertension, venous emboli, benign prostatic hypertrophy (BPH), hyperlipidemia, seizures, nasal</p>	F000282	<p><b>F 282</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>(1) Immediate actions taken for those residents identified:</b></p> <p>1. Resident #H: The medications Synthroid, Topiramate,</p>	12/01/2014	

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	<p>congestion, constipation, anxiety, hypothyroidism and atrial fibrillation.</p> <p>The Medication Administration record, dated 10/14, indicated the resident had not received the Lisinopril at 8 p.m. on October 19, 21, and 22, 2014 and had not received the Labetalol at 4 p.m. on October 18, 19, and 20, 2014.</p> <p>A Physician's Order, dated 09/05/13, indicated Flomax 0.4 mg (BPH), one tablet at bedtime.</p> <p>A care plan, goal target date of 01/14/15, indicated the residents received medications for BPH, the interventions included to assess for side effects of the medication.</p> <p>The MAR, dated 10/14, indicated the resident had not received the Flomax on October 18, 19, 20, and 21, 2014.</p> <p>A Physician's Order, dated 05/25/14, indicated pravastatin (hyperlipidemia) 20 mg, one capsule every evening.</p> <p>A care plan, target date of 01/14/15, indicated the resident received medications for increased cholesterol. The interventions included, administer medications as ordered.</p>		<p>Pravastatin, Zyrtec, Docusate, Tizanidine, Alprazolam and Triamcinolone are present in the Medication Cart and Treatment Cart. The physician was notified of missed medication doses by the Interim Director of Nursing on 11/18/14. The physician was notified on 11/14/14 of Lisinopril and Labetalol administered and/or held outside of blood pressure parameters on 10/8/14, 10/14/14, 10/15/14 &amp; 10/16/14.</p> <p>2. Resident #G: The physician was notified on 11/14/14 of medications Catapres and Lipitor not administered from the EDK.</p> <p>3. Resident #E: The physician was notified and a new order was obtained for herpsoriasis. The physician was notified on 11/14/14 of treatment Salicylic Acid Cream was not administered on 7/10/14, 7/13/14, 7/15/14, 8/15/14 &amp; 8/29/14.</p> <p><b>(2) How the facility identified other residents:</b></p> <p>A 100% audit of Medication Administration and Treatment Administration Records was completed on 11/7/14 for missing entries.</p> <p><b>(3) Measures put into place /System Changes:</b></p> <p>Licensed nurses will receive education on completing</p>				

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	<p>The MAR, dated 10/14, indicated the resident had not received the pravastatin on October 18, 19, 21, and 22, 2014.</p> <p>A Physician's Order, dated 06/19/14, indicated Synthroid 25 mcg (microgram) (hypothyroidism), one time a day.</p> <p>A care plan, target dated of 01/14/15, indicated the resident had a diagnosis of hypothyroidism. The goal indicated the resident would be free from signs and symptoms of hypothyroidism.</p> <p>The MAR, dated 10/14, indicated the resident had not received the Synthroid on October 13 and 15, 2014.</p> <p>A Physician's Order, dated 09/05/13, indicated topiramate 50 mg (anti-seizure), one tablet at bedtime.</p> <p>A care plan, target date of 01/14/15, indicated the resident had a seizure disorder. The interventions included to give seizure medication as ordered.</p> <p>The MAR, dated 10/14, indicated the resident had not received the topiramate at 8 p.m. on October 19, 21, and 22, 2014.</p> <p>A Physician's Order, dated 09/05/13, indicated Zyrtec 10 mg (nasal</p>		<p>documentation of Medication/Treatment Administration Records, and ensuring medication/ treatment orders and parameters are followed according to physician orders and care plan.</p> <p>Medication Administration and Treatment Administration Records will be reviewed at least 3 days a week to ensure medications were documented and administered as ordered.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p><b>(4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in Quality Assurance meeting monthly x3 months, and quarterly x1 for a total of 6 months.</p> <p><b>(5) Date of Compliance:</b> <b>12/1/14</b></p>	

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	<p>congestion), one tablet at bedtime.</p> <p>A care plan, target date of 01/14/15, indicated the resident received medication for allergy symptoms. The interventions included, administer medications as ordered.</p> <p>The MAR, dated 10/14, indicated the resident had not received the Zyrtec on October 18, 19, 21, and 22, 2014.</p> <p>The Physician's Orders, dated 09/05/13, indicated docusate sodium 100 mg (stool softener), one capsule two times daily and Senna Lax (laxative), one tablet three times a day.</p> <p>A care plan, target date of 01/14/15, indicated the resident was at risk for constipation. The interventions included, administer medications as ordered.</p> <p>The MAR, dated 10/14, indicated the docusate sodium had not been administered at 4 p.m. on October 18, 19, and 21, 2014 and the Senna Lax had not been administered at 4 p.m. on October 19, 20, and 21, 2014.</p> <p>A Physician's Order, dated 11/21/13, indicated, tizanidine 4 mg (muscle relaxant), one tablet two times a day.</p>			

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	<p>A care plan, target date of 01/14/15, indicated the resident received medications for muscle relaxation and tremors. The interventions included, administer medications as ordered.</p> <p>The MAR, dated 10/14, indicated the tizanidine had not been administered at 4 p.m. on October 18, 19, 20, and 21, 2014.</p> <p>A Physician's Order, dated 09/05/14, indicated alprazolam (anti-anxiety) 0.75 mg three times a day.</p> <p>A care plan, target date 01/14/15, indicated the resident exhibits very anxious symptoms. The interventions included, medications as ordered.</p> <p>The MAR, dated 10/14, indicated the alprazolam had not been administered at 5:50 a.m. on October 13 and 15, 2014 and at 10 p.m. on October 19, 21, 22. and 23, 2014.</p> <p>A Physician's Order, dated 09/05/14, indicated triamcinolone acetonide cream 0.1% cream (rash/dry skin), apply to bilateral lower extremities and feet topically twice a day.</p> <p>A care plan, target date 01/14/15, indicated the resident received the triamcinolone cream for dry skin. The</p>			

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	<p>interventions included, the staff will do treatments as ordered.</p> <p>The MAR, dated 10/14, indicated the treatment had not been completed on October 18, 19, 20, and 21, 2014 at 4 p.m.</p> <p>During an interview on 11/05/14 at 4:15 p.m., the Interim Director of Nursing (DoN) indicated the computer had been down in October and paper medication records had been used. (paper medication records were reviewed)</p> <p>During an interview on 11/06/14 at 2:30 p.m., the Interim DoN indicated she did not know whether or not the resident received the above medications as ordered.</p> <p>No further paper MARS were received from the facility at the time of the exit on 11/06/14 at 5:15 p.m.</p> <p>The Physician Orders, dated 09/05/13, indicated Lisinopril 20 mg (anti-hypertensive), one tablet every 12 hours (hold if systolic blood pressure was 100 or less) and Labetalol 400 mg (anti-hypertensive) two times a day (hold if systolic blood pressure was 100 or less).</p>						

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	<p>A care plan, goal target date of 01/14/15, indicated the resident had hypertension. The interventions included, to give the anti-hypertensive medications as ordered.</p> <p>The MAR, dated 10/14, indicated the resident's blood pressure at 8 a.m. on 10/08/14 was 90/61 and the Labetalol was administered to the resident.</p> <p>The MAR, dated 10/14, indicated the resident's blood pressure at 8 p.m. on 10/13/14 was 101/62 and the Lisinopril was held, 10/15/14 was 102/68 and the Lisinopril was held, and 10/16/14 the blood pressure was 102/62 and the Lisinopril was held.</p> <p>The MAR, dated 11/14, indicated the resident's blood pressure at 8 a.m. was 90/64 and the 8 a.m. Labetalol was administered to the resident.</p> <p>During an interview on 11/06/14 at 9 a.m., the Administrator indicated the physician orders were not being followed for the blood pressure parameters.</p> <p>2. Resident #G's record was reviewed on 11/06/14 at 12:10 p.m. The resident's diagnoses included chronic obstructive pulmonary disease, hypertension, hyperlipidemia, and congestive heart failure.</p>						

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	<p>A Nurses' Progress Note, dated 11/02/14 (Sunday) at 3:35 p.m., indicated the resident was readmitted into the facility from the hospital.</p> <p>Physician Orders, dated 11/02/14, indicated:</p> <p>Catapres tablet (for blood pressure) 0.2 mg, twice daily</p> <p>Lipitor (hyperlipidemia) 10 mg, one tablet one time a day</p> <p>The MAR, dated 11/14, indicated the Catapres had not been given on 11/03/14 at 8 a.m. or 4 p.m. and the Lipitor had not been given at 8 a.m. on 11/03/14.</p> <p>A Nurses' Progress Note, dated 11/03/14 at 1:11 p.m., indicated the facility was awaiting medications from the pharmacy.</p> <p>During an interview on 11/06/14 at 1:50 p.m., the Interim DoN indicated if the medication was not available the facility had an Emergency Drug Kit the Nurses' could have gotten the medications from if they were in the kit.</p> <p>Review of the list of medications available in the Emergency Drug Kit, received from the Interim DoN on</p>						

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	<p>11/06/14 at 2 p.m., indicated atorvastatin (generic for Lipitor) 10 mg and clonidine (generic for Catapres) 0.1 mg ( would have to give two) was available in the Emergency Drug Kit.</p> <p>3. During an observation on 11/05/14 at 11:50 a.m., Resident #E was sitting in the dining room. The resident was scratching her wrist. There were dried patches of skin on the inside of the residents wrist. The resident indicated she has had the areas for a long time on her wrist and elbows. She indicated she had psoriasis.</p> <p>Resident #E's record was reviewed on 11/06/14 at 10:35 a.m. The resident's diagnoses included, but were not limited to, dementia and psoriasis.</p> <p>A Physician's Order, dated 07/09/14, indicated an order for salicylic acid cream 6% (for psoriasis), apply to the scaly areas topically every evening and night shift for 12 weeks. The order was scheduled to be discontinued on 10/01/14.</p> <p>The MAR, dated 07/14, indicated the salicylic acid cream 6% was not administered on 07/10/14 on the evening shift, 07/13/14 on the evening shift, and 07/15/14 on the night shift.</p>						

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	<p>The MAR, dated 08/14, indicated the salicylic acid cream 6% was not administered on 08/15/14 and 08/29/14 on the evening shift.</p> <p>The MAR, dated 09/14, indicated the salicylic acid cream 6% was administered on 09/03/14 and 09/04/13 on the evening shift and 09/15/14 and 09/25/14 on the night shift.</p> <p>A Physician's Order, dated 10/19/14, indicated an order for menthol-zinc oxide (skin treatment) apply to the resident's back every shift for heat rash on lower back.</p> <p>The MAR, dated 10/14, indicated the menthol-zinc oxide had not been administered on 10/21/14 on the evening and night shift and 10/30/14 on the evening shift.</p> <p>During an interview on 11/06/14 at 12:40 p.m., the Interim DoN indicated she did not realize the resident had areas on the arms.</p> <p>During an interview on 11/06/14 at 2:30 p.m., the Interim DoN indicated the resident still had psoriasis on her arms and the resident's Physician would be notified. She indicated she did not know</p>			

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F000333 SS=D	<p>if the resident received the cream or not.</p> <p>This Federal Tag relates to complaint IN00158562.</p> <p>3.1-35(g)(2)</p> <p>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 interview, the facility failed to ensure a resident was free of a significant medication error, related to an order for Coumadin (blood thinner) being discontinued without a Physician's Order, which resulted in a resident not receiving the Coumadin as ordered for 6 days, for 1 of 3 residents reviewed for medications in a total sample of 9. (Resident #H)</p> <p>Findings include:</p>	F000333	<p><b>F 333 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided asevidence of the facility's desire to comply with the regulations and to continueto provide quality care. <b>(1) Immediate actions taken forthose residents identified:</b> Resident #H: The physician was notified on 10/24/14 thatthe resident had not received his</p>	12/01/2014	

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	<p>Resident #H's record was reviewed on 11/05/14 at 2 p.m. The resident's diagnoses included, but were not limited to, stroke, hypertension, venous emboli, and atrial fibrillation.</p> <p>A Physician's order, dated 10/02/14, indicated an order for Coumadin 5 milligrams (mg), one tablet in the evening for stroke and venous embolism.</p> <p>A Physician's order, dated 10/13/14, indicated to hold the Coumadin on 10/13/14 for one day.</p> <p>A Physician's Telephone Order, dated 10/16/14 at 12:20 a.m., indicated an order for Coumadin 5 mg one time only for Coumadin therapy for one day.</p> <p>A Physician's Telephone Order, dated 10/16/14 at 12:22 a.m., indicated an order for Coumadin 5 mg in the evening for Coumadin therapy.</p> <p>A Telephone Order, dated 10/16/14 at 11:35 a.m., indicated to discontinue the Coumadin 5 mg in the evening due to it was a duplicate order.</p> <p>A Medication Administration Record (MAR), dated 10/14, indicated Coumadin 5 mg was resumed and administered to</p>		<p>ordered Coumadin from 10/17/14 through 10/23/14 when med error was identified. All nursing managers were In-Serviced by the DON on 11/7/14 about not discontinuing duplicate orders until they have been opened and reviewed. <b>(2) How the facility identified other residents:</b> All residents receiving Coumadin have been audited with no negative findings.</p> <p><b>(3) Measures put into place /System Changes:</b> Licensed nurses will be re-educated regarding Coumadin order input verification and Coumadin administration. Coumadin labs and orders will be audited at least 3x/week to ensure orders following physicians orders and are present on the medication administration record. The Director of Nursing or designee will be responsible for oversight of these audits. <b>(4) How the corrective actions will be monitored:</b> The results of these audits will be reviewed in Quality Assurance meeting monthly x3 months, and quarterly x1 for a total of 6 months. <b>(5) Date of Compliance: 12/1/14</b></p>		

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	<p>the resident on October 14, 15, and 16.</p> <p>The MAR, dated 10/14, indicated no further Coumadin had been administered to the resident from October 17 through 23, 2014 and Coumadin 5 mg had been resumed and administered on 10/24/14.</p> <p>A Nurses' Progress Note, dated 10/17/14 at 3:11 p.m., indicated the Physician had been notified of the PT (prothrombin time) and INR (International Normalized Ratio) (clotting times) results, which were, PT- 25.8 (normal 11-13) and INR 2.3 (therapeutic range 2.0-3.0) and an order was received to continue the Coumadin 5 mg and obtain another PT/INR on 10/20/14.</p> <p>A PT/ INR laboratory result, dated 10/20/14, indicated the resident's PT was 27.9 and INR was 2.5. Hand written on the result was an order to continue Coumadin 5 mg every evening and repeat the PT/INR on 10/27/14. (resident had not received the Coumadin 5 mg since 10/16/14)</p> <p>A Medication Error form, dated 10/24/14, indicated there was no Coumadin order due to a transcription error. Other intervention necessary due to the error, indicated the INR was low and to continue with current dose (5 mg)</p>			

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	<p>and to obtain a PT/INR on 10/27/14.</p> <p>During an interview on 11/6/14 at 3:30 p.m., with the Administrator, the Interim Director of Nursing (DoN) and the Assistant Director of Nursing (ADON), the ADoN indicated when the error was found, the facility reran all the MARs all over again and went back through order sheets to ensure all new orders were put into the computer, since the computer had been down.</p> <p>Further interview on 11/6/14 at 4 p.m., LPN #1, (Nurse who transcribed the 10/16/14 at 12:20 a.m., indicated an order for Coumadin 5 mg one time only for Coumadin therapy for one day and the 10/16/14 at 12:22 a.m. order for Coumadin 5 mg in the evening for Coumadin therapy), indicated she had wrote the order for the one time dose on 10/16/14 because the resident had an order for a PT/INR on 10/17/14 and on 10/17/14 after the results of the PT/INR came in, the Physician wanted the 5 mg of Coumadin continued. She indicated she had not checked the MAR because the order had not changed from the order on 10/16/14.</p> <p>Further interview on 11/6/14 at 4:10 p.m., the ADoN indicated she had seen the Coumadin orders written on 10/16/14</p>						

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F000371 SS=F	<p>and saw there were two orders for Coumadin 5 mg, so she discontinued the one of the Coumadin 5 mg order due to it being duplicate. She indicated she had not opened up the full order to see the orders were two different orders. She indicated she was unaware what caused the Coumadin error until the time of this interview. The ADoN indicated when the error was found, the facility had just checked the residents with new orders and not other residents orders and MARS.</p> <p>This Federal Tag relates to complaint IN00158562.</p> <p>3.1-48(c)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to store, prepare, distribute, and serve food under sanitary conditions,</p>	F000371	<p><b>F 371</b>  The facility requests papercompliance for this citation. The filing of this plan</p>	12/01/2014			

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	<p>related to black substance on a wall and PVC pipe and peeling paint and plaster on the wall around and under the dishwasher and splattered dried food on the wall under the hand washing sink for 1 of 1 kitchens, which serve food and washed dietary equipment for 63 resident in the facility.</p> <p>Findings include:</p> <p>During an observation on 11/06/14 at 3 p.m. with the Dietary Manager present, there was a black substance on the wall behind the dish washer and on the PVC pipe under the dishwasher. The plaster was crumbling on the wall under the counter top by the dishwasher with a dark substance on the plaster. The paint above the counter was peeling.</p> <p>During an interview at the time of the observation, the Dietary Manager indicated the black substance may be mold or food. She indicated they try to clean the area once a week and the Director of Maintenance was aware of the areas.</p> <p>Under the hand washing sink there was dried splatters on the wall. The Dietary Manager indicated it was food splatters.</p> <p>During an interview on 11/06/14 at 3:10</p>		<p>of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided asevidence of the facility's desire to comply with the regulations and to continueto provide quality care.</p> <p><b>(1) Immediate actions taken forthose residents identified:</b></p> <p>1. The repair of the wall under the dishwasher willbegin on Monday 11/24/14. 2. The food splatter under the hand washing sink andblack substance under the dishwasher on the PVC pipe was immediately clean by the Dietary Manager on 11/6/14.</p> <p><b>(2) How the facility identifiedother residents:</b></p> <p>All walls were checked by the DietaryManager for food splatter, peeling paint or black substances.</p> <p><b>(3) Measures put into place /System Changes:</b></p> <p>The Dietary Cleaning list was updatedon 11/19/14 to include monitoring for food splatter on walls.</p> <p>Dietary Staff will be educated by DietaryManager regarding cleaning schedule.</p>		

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F000425 SS=D	<p>p.m., the Director of Maintenance indicated he was not aware of the mold and the Corporate office was aware of the condition of the walls.</p> <p>During an interview on 11/06/14 at 5:15 p.m., the Administrator indicated the Corporate office was getting estimates for the wall in the kitchen.</p> <p>This Federal Tag relates to complaint IN00158562.</p> <p>3.1-21(i)(3)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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,</p>		<p>The Dietary Manager/Designee willreview the cleaning schedules 3 X a week and place findings on and audit tool.</p> <p>The Maintenance Director will completewalking round audit of the walls in the Dietary Department and the pipes underthe dishwasher 2 X a week.</p> <p>TheAdministrator will be responsible for oversight of these audits.</p> <p><b>(4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will bereviewed in the Quality Assurance meeting monthly x3, then quarterly x1 for atotal of 6 months.</p> <p><b>(5) Date of Compliance:</b> 12/1/14</p>		

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	<p>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 record review and interview, the facility failed to ensure medications were obtained for residents, related to medications not available to administer to a resident as ordered by the residents' Physician, for 2 of 3 residents reviewed for medication administration in a total sample of 9. (Residents #G and #H)</p> <p>Findings include:</p> <p>1. Resident #H's record was reviewed on 11/05/14 at 2 p.m. The resident's diagnoses included, but were not limited to, seizures and anxiety.</p> <p>A Physician's Order, dated 09/05/13, indicated topiramate 100 mg (milligram) (anti-seizure), one tablet daily.</p> <p>The Medication Administration Record, dated 10/14, indicated the topiramate 100 mg had not been administered at 5:59 a.m. on 10/20/14.</p> <p>A Nurses' Progress Note, dated 10/20/14 at 7:06 a.m. indicated the medication had</p>	F000425	<p><b>F 425</b></p> <p><b>The facility requests paper compliance for this citation.</b></p> <p>The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p><b>1. Immediate actions taken for those residents identified:</b></p> <p>1. Resident #H: The physician was notified on 11/14/14 that Topiramate was not administered on 10/20/14 and on 10/27, 10/30 and 10/31/14 Paxil was not administered.</p> <p>2. Resident #G: The physician was notified on 11/14/14 that Clonazepam had not been administered on 11/3/14, 11/4/14 and 11/5/14 and Carvedilol had not been administered on 11/3/14. The physician was also notified that Xopenex nebulizer had not been administered on 11/3/14, 11/4/14</p>	12/01/2014	

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	<p>not been available and the pharmacy was notified.</p> <p>A Physician's Order, dated 08/22/14, indicated Paxil (antidepressant) 40 mg one time a day for anxiety.</p> <p>The MAR, dated 10/14, indicated the Paxil had not been given on October 27, 30, and 31, 2014.</p> <p>A Nurses' Progress Note, dated 10/27/14 at 10:15 a.m., indicated the Paxil had not been administered due to the medications was not available and the Pharmacy had been notified.</p> <p>A Nurses' Progress Note, dated 10/30/14 at 8:53 a.m., indicated the Paxil had not been administered due to the medication was not available and the Pharmacy contacted.</p> <p>A Nurses' Progress Note, dated 10/31/14 at 9:01 a.m., indicated the Paxil had not been administered due to the medication was not available from the pharmacy.</p> <p>2. Resident #G's record was reviewed on 11/06/14 at 12:10 p.m. The resident's diagnoses included chronic obstructive pulmonary disease, hypertension, and congestive heart failure.</p>		<p>and 11/4/14. All medications were received in house by evening of 11/5/14.</p> <p>3. The pharmacy was notified on 11/7/14 and Education thru In-Services has been scheduled for all licensed personnel.</p> <p><b>1. How the facility identified other residents:</b></p> <p>A chart to cart audit began on 11/11/14 and a second audit completed on 11/19/14 to assure all medications are present per physicians' orders. Medications were obtained as identified.</p> <p><b>(3) Measures put into place / System Changes:</b></p> <p>Licensed nurses will be educated regarding Medication Administration, use of EDK, medication documentation. Pharmacy will in-service nurses regarding medication ordering procedures.</p> <p>Pharmacy communication logs have been placed at each nursing station and nurses were educated on 11/13/14 regarding procedures to follow if medication is not available.</p> <p>A medication audit will be completed on at least 5 residents per week to ensure medications are available.</p>				

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	<p>A Nurses' Progress Note, dated 11/02/14 (Sunday) at 3:35 p.m., indicated the resident was readmitted into the facility from the hospital.</p> <p>Physician Orders, dated 11/02/14, indicated: carvedilol (cardiac medication) 12.5 mg, one tablet two times day for congestive heart failure</p> <p>clonazepam (anti-anxiety) 0.5 mg, one tablet, twice a day for anxiety</p> <p>acetylcysteine solution (breathing medication) 10%, inhale one vial by nebulizer four times a day</p> <p>xopenex (breathing medication) nebulizer solution 0.31 mg per 3 milliliters (ml), one vial by nebulizer every six hours</p> <p>The MAR, dated 11/14, indicated the carvedilol had not been administered on 11/3/14 at 8 a.m., the clonazepam had not been administered on November 3, 4, and 5, 2014 at 8 a.m. and November 3 and 4, 2014 at 4 p.m., the xopenex nebulizer had not been administered on 11/03/14 at 6 a.m., 11/03/14 at 12 p.m., 11/03/14 at 6 p.m., 11/05/14 at 6 a.m., 11/5/14 at 12 p.m., and the acetylcysteine solution had not been administered on 11/03/14 at 12 p.m. and 8 p.m.</p>		<p>MAR audit will be completed at least 3x/week to identify any medications documented as unavailable.</p> <p>The Director of Nursing or designee will be responsible for oversight of these audits.</p> <p><b>(4) How the corrective actions will be monitored:</b></p> <p>The results of these audits will be reviewed in the Quality Assurance meeting monthly x3, then quarterly x1 for a total of 6 months.</p> <p><b>(5) Date of Compliance:</b> 12/1/14</p>	

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	<p>A Nurses' Progress Note, dated 11/03/14 at 1:11 p.m., indicated the facility was awaiting medications from the pharmacy.</p> <p>A Nurses' Progress Note, dated 11/04/14 at 4:56 p.m., indicated the Pharmacy had not delivered the clonazepam to the facility.</p> <p>A Nurses' Progress Note, dated 11/05/14 at 8:22 a.m., indicated the Pharmacy had not yet delivered the xopenex nebulizer solution.</p> <p>A Nurses' Progress Note, dated 11/05/14 at 8:30 a.m., indicated the Pharmacy had not delivered the clonazepam to the facility</p> <p>A Nurses' Progress Note, dated 11/05/14 at 11:38 a.m., indicated the Pharmacy had not delivered the xopenex nebulizer solution.</p> <p>During an interview on 11/05/14 at 8:30 a.m., LPN #1 indicated the facility has had problems getting medications from the Pharmacy timely. She indicated this occurs frequently and if the resident still does not have medications for more than one day, she will inform her Supervisor.</p> <p>During an interview on 11/05/14 at 9</p>			

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	<p>a.m., LPN #2 indicated she has had problems receiving medications from the Pharmacy. LPN #2 indicated she has seen an improvement with getting medications.</p> <p>During an interview on 11/05/14 at 3:45 p.m., LPN #3 indicated she has had trouble getting the medications delivered from Pharmacy in a timely manner. She indicated it occurs frequently. She indicated this occurs with both new and routine medications. She indicated the Administrator has been informed when there were. problems.</p> <p>During an interview on 11/05/14 at 4:15 p.m., the Administrator indicated they have discussed the late arrival of medications from the Pharmacy. She indicated the facility had a back up Pharmacy the facility can call. The Interim DoN indicated the Corporation has had meetings with the Pharmacy about the issues. She indicated if the medications were not delivered the staff should notify the Supervisor. She indicated the Pharmacy says they receive the orders too late.</p> <p>During an interview on 11/06/14 at 9 a.m., the Interim DoN indicated the Corporation had a meeting with the Pharmacy and she had just received an,</p>						

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	<p>"action plan" on 11/05/14. She indicated she had just started an audit of missing medications.</p> <p>During an interview on 11/06/14 at 1:50 p.m., the Interim DoN indicated if the medication was not available, and not in the Emergency Drug Kit, the Nurse was to call the Physician and notify the Nurse Manager. She indicated the Nurses' were being inserviced today. She indicated she had been notified on 11/05/14 about Resident #G not having his medications.</p> <p>A Pharmacy delivery schedule, received from the Interim Director of Nursing (DoN), on 11/06/14 at 11:43 a.m. the cut-off time was 9 a.m. and the delivery time during the week was 12 p.m., cut-off time was 9 p.m. and delivery was 12 a.m., and on the week-end the cut-off time was 6 a.m. and delivery time was 11 a.m. and cut-off time 2 p.m. and delivery 4 p.m.</p> <p>This Federal Tag relates to complaint IN00158562.</p> <p>3.1-25(a)</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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