

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155367	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/25/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-SYCAMORE VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 W SYCAMORE ST KOKOMO, IN 46901
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F000000	<p>This visit was for the Investigation of Complaints IN00152517 and IN00152546.</p> <p>Complaint: IN00152517 Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F425.</p> <p>Complaint IN00152546 Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey dates: July 23, 24 & 25, 2014</p> <p>Facility Number: 000258 Provider Number: 155367 AIM Number: 100289160</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census Bed Type: SNF/NF: 94 Total: 94</p> <p>Census Payor Type: Medicare: 9 Medicaid: 70 Other: 15 Total: 94</p>	F000000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
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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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F000157 SS=D	<p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on July 30, 2014.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in</p>			

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	<p>§483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview the facility nursing staff failed to immediately inform a resident's physician, in that when residents had specific orders upon admission to the facility, and the pharmacy failed to provide the medications for administration, the nursing staff failed to notify the resident's physician or the Medical Director for possible intervention. This deficient practice affected 2 of 3 residents sampled for admission to the facility. (Resident A and C)</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 07-23-14 at 10:45 a.m. Diagnoses included, but were not limited to, ESRD (End Stage Renal Disease), convulsions, hypertension, pain, cerebral vascular accident, coagulation deficits, diabetes mellitus and edema. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 07-11-14 at</p>	F000157	Physician for Res "A" and Res "C" aware that the medications were not available in a timely manner upon return from the hospital and that there was a delay in Res "A" and Res "C" receiving them. All residents who have been admitted to the facility in past 30 days have been reviewed to ensure they have all their medications available to them. The physician of any resident who was identified to have had a delay in receiving their medications upon admission has been notified of that delay. Licensed nursing staff to be in-serviced that the physician needs to be notified any time medications for a new admission are not available within 4 hours of the time pharmacy was notified of the new orders. The nurse will need to document in the nurses note that the physician has been notified. UM/designee to audit all new admissions to ensure that they received their medications timely and that the physician was notified any time there was a delay. These audits will be completed every day x 90 days, 3 times weekly x 90 days, then weekly thereafter. The results of	08/18/2014

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	<p>6:00 p.m.</p> <p>A review of a hospital handwritten note, dated 07-11-14 indicated the resident was accepted by the facility on 07-11-14 at 10:00 a.m., and then at 10:39 a.m., "Medication orders faxed to Golden Living, 12:25 p.m. Additional orders faxed to SNF [skilled nursing facility]."</p> <p>Although the physician orders were received at the facility at 10:00 a.m., the Unit Manager indicated the physician orders were not faxed to the pharmacy at that time, because "sometimes once a resident is discharged from the hospital, the orders occasionally change."</p> <p>Upon admission to the facility, the resident arrived with the following orders:</p> <p>"Accu-checks [blood test to determine the blood sugar level in the resident] BID [two times a day] related to Diabetes, Miconazole Barrier Cream, Protein powder two times a day, Amlodipine Besylate Tablet 10 mg [milligrams] [a medication to control blood pressure], Bisacodyl Suppository 10 mg one time a day - 1 day on and 1 days <sic> off for constipaion <sic>, Coumadin [a blood thinner medication] Tablet 7.5 mg one tablet by mouth in the</p>		<p>these audits will be reviewed at QAPI x 6 months to track for any trends. If any trends identified then the audits will be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>				

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	<p>afternoon, Granulex Aerosol Solution 0.12-788-87 mg/gm [milligrams per gram] topically every evening and night shift for portect <sic> skin, Labetalol HCL 200 mg [a medication for blood pressure control] 200 mg two times a day, Lyrica Capsule 50 mg by mouth at bedtime [a medication to control pain], Metoclopramide HCL [a medication to aide in reflux disease] 5 mg before meals, Nephro-Vite 0.8 mg one by mouth one time a day related to End Stage Renal Disease [a supplement], Synthroid 50 mcg [micrograms] in the morning [a medication to aide in thyroid therapy]."</p> <p>A review of the nursing progress notes, dated 07-11-14 through 07-15-14 indicated the following:</p> <p>"07-11-14 at 20:19 [8:19 p.m.] - New Admit - Res. arrived to the facility at 6:28 p.m. All meds faxed to [name of pharmacy] at 20:06 [8:06 p.m.] and face sheet for medication delivery"</p> <p>"07-12-14 at 10:35 a.m. Medication no <sic> available. Pharmacy called times 2."</p> <p>"07-12-14 13:37 [1:37 p.m.] Late Entry note - at 8:45 a.m. unable to get residents meds from ADU [automatic dispensing unit for medications]. Called Alexia Rx,</p>			

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	<p>stated to them that I was unable to get meds from ADU, pharmacy technician stated that was because there was no call to advise them of a new resident. Stated the orders were right there beside her and she hadn't started them yet, but will start them. Will send them on the next run."</p> <p>"07-12-14 at 21:32 [9:32 p.m.] medication not available from the pharmacy."</p> <p>"07-12-14 at 21:33 [9:33 p.m.] medications not availed from the pharmacy."</p> <p>"07-14-14 at 10:10 a.m. NP [nurse practitioner] in to see resident, spoke with [family member] received multiple new orders."</p> <p>Further review of the progress notes indicated that on 07-12-14 at 23:04 [11:04 p.m.] indicated, "[Family member] requested SS [sliding scale] order for glucose control. Orders received from NP [nurse practitioner] for SS and Accuchecks QID [four times a day]."</p> <p>A review of the Electronic Medication Record on 07-24-14 at 10:30 a.m., revealed the following: Amlodipine Besylate 10 mg not</p>			

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	<p>administered to the resident until 07-13-14 at 9:00 a.m., Bisacodyl Suppository 10 mg not administered to the resident until 07-12-14 at 5:00 p.m., Coumadin 7.5 mg was not administered until 07-12-14 at 5:00 p.m., Famotidine 20 mg not administered until 07-15-14 at 2100 [9:00 p.m.], Levothyroxine 50 mcg not administered until 07-13-14 at 6:00 a.m., Methlnslytrexone Bromide 12 mg/0.6 ml [milliliters] until 07-15-14 at 9:00 a.m., Nephro-Vite tablet 0.8 mg was not administered until 07-13-14, Miralax 17 grams was not administered until 07-15-14.</p> <p>The Electronic Medication Record indicated that the resident did not receive the Labetalol 200 mg until 07-12-14 at 9:00 p.m., Protein Powder 1 scoop per g-tube [gastrostomy feeding tube] was not available for the resident until 2100 [9:00 p.m.] on 07-12-14, Senna Tablet 8.6 mg was not available for the resident until 07-16-14 at 9:00 a.m., Metoclopramide HCL 5 mg was not available for the resident until 1630 [4:30 p.m.] on 07-12-14,</p> <p>The resident required physician intervention on 07-14-14 when she had elimination needs and had gone without a bowel movement from the time of admission thru 07-13-14 at 12:22 p.m.,</p>			

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	<p>when the nursing staff had to contact the physician for an enema, since she had not received the physician prescribed medications related to constipation. The Senna tablets were administered on 07-15-14 at 9:00 a.m., and Miralax was received and not administered until 07-16-14 at 9:00 a.m.</p> <p>The clinical record lacked an indication the physician was notified of the delay in the prescribed medications.</p> <p>2. The record for Resident "C" was reviewed on 07-23-14 at 11:10 p.m. Diagnoses included, but were not limited to, late effect cerebrovascular accident, constipation, anxiety, urinary retention, hypothyroidism, hemiplegia, dysphagia, neurogenic bladder and diabetes mellitus. These diagnoses remained current at the time of the record review. Resident "C" was admitted to the facility on 07-18-14.</p> <p>The record indicated the resident had admission physician orders for Lidocaine Patch 5 % - apply to posterior neck incision topically two times a day for incisional pain on in a.m. and off hs (bedtime). A review of the Electronic Medical Record indicated the resident did not receive the pain patch at 9:00 a.m., as prescribed. In addition the resident had a physician order for Norco Tablet (a</p>			

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	<p>controlled analgesic medication) 10-325 mg one tablet by mouth five times a day for chronic pain. The Electronic Medical Record indicated the pain medication was not administered because it was unavailable and eventually administered on 07-19-14 at 1300 (1:00 p.m.). An additional topically pain patch, Flector 1.3 % - which directed the nursing staff to apply at 6:00 a.m. and then again at 9:00 p.m., but the resident did not receive the medication until 07-20-14 at 9:00 p.m.</p> <p>A review of the Progress Notes indicated the following:</p> <p>"07-18-14 at 23:41 [11:41 p.m.] Resident was returned to facility by transportation for [name of local area hospital] by transport and orders."</p> <p>"07-18-14 23:43 [11:43 p.m.] at 20:00 [8:00 p.m.] MD called and medication orders clarified."</p> <p>"07-19-14 7:00 a.m. - Medications unavailabe from pharmacy."</p> <p>"07-19-14 at 13:58 [1:58 p.m.] Pharmacy notified of medications times three, able to get medications at 1:00 p.m. after calling the pharmacy 4 times."</p>			

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	<p>"07-19-14 at 14:26 [2:26 p.m.] Lidocaine patch unavailable. pharmacy notified. Stated it would be on the next run."</p> <p>"07-19-14 at 14:31 [2:31 p.m.] Flector patch unavailable. Pharmacy stated it would be on next run."</p> <p>The clinical record lacked an indication the physician was notified of the delay in the prescribed medications.</p> <p>3. A review of the facility policy on 07-24-14 at 8:50 a.m., titled "Notification of Change in Resident Health Status," undated, indicated the following:</p> <p>"The facility will consult the residents physician, nurse practitioner or physician assistant, and if known notify the residents legal representative or an interested family member when there is: Criteria: Appropriate notification time: immediate Nursing judgement is an integral part of the skilled care provided in this facility therefore, such judgement must be applied in a case by case basis in keeping with acceptable nursing practice."</p> <p>This Federal tag relates to Complaint IN00152517.</p> <p>3.1-5(a)</p>						

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F000323 SS=G	<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 failed to implement interventions for resident's who were identified at risk for falls, in that when resident's fell and sustained injuries to include fractures and subdural hematoma's, the nursing staff failed to develop other strategies or assistive devices to alert the nursing staff of unassisted ambulation in order to supervise and keep the resident's safe and free from additional injuries. In addition, the facility failed to ensure supervision and establish a system to prevent accidents, in that when a resident was transported via a wheelchair to her room, the nursing staff failed to ensure the resident's arm was not bumped into inanimate objects which resulted in a skin tear.</p> <p>This deficient practice affected 4 of 7 resident's sampled for injuries in a total sample of 10. (Resident's "G", "B", "F" and "I"). Resident G was identified as a fall risk, therapy was implemented as ordered timely and the resident had a fall</p>	F000323	<p>The facility is disputing this deficiency. The facility feels that it did have interventions in place to reduce the risk of falls and fall-related injuries. Care plans for Res "G", Res "B", Res "F", and Res "I" have been reviewed and updated to ensure interventions are in place to help keep residents safe and help reduce the risk of any further injuries from accidents. Care plans for all residents identified at risk for falls have been reviewed and updated as needed to ensure interventions are in place to help reduce the risk of falls or fall related injuries. Nursing staff to be in-serviced on notifying the nurse manager on duty at the time a resident falls to review circumstances of fall and to ensure an appropriate intervention is put in place. IDT (interdisciplinary team)/designee to review falls every day to try and identify cause of fall and ensure appropriate interventions which may include the need for some type of assistvie device are in place to reduce the risk of further falls or fall related injury. IDT to also meet two times monthly and review residents who have had</p>	08/18/2014
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	<p>sustaining a hip fracture with subsequent falls after the fall with a fracture.</p> <p>Findings include:</p> <p>1. The record for Resident "G" was reviewed on 07-25-14 at 12:30 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, psychotic disorder with hallucination, senile dementia, Parkinson's and anxiety. These diagnoses remained current at the time of the record review.</p> <p>A review of the pre-admission assessment, dated 09-09-11 indicated the resident required safety cues and reminders.</p> <p>A review of the resident's MDS assessment, dated 04-16-14 indicated the resident had severe cognitive impairment, was not steady, and only able to stabilize with human assistance in the areas of moving from seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfer.</p> <p>The resident had plans of care which identified the resident at risk for falls, related to impaired cognition and decision making skills, poor safety awareness and a diagnosis of Parkinson's.</p>		<p>falls in past month and ensure that interventions continue to be appropriate or may need changed based on resident's current needs. Therapy to screen every resident with a fall to determine if therapy intervention is needed which may include screening for the need for some type of assistive device. Alzheimer's Care Director to review activities calendar on Alzheimer's Care Unit to ensure activities are scheduled during peak hours when residents are the most active and apt to attend the activity which is supervised by a staff member. Licensed nursing staff to be in-serviced that they need to be available out in the hallways during busy times when the CNAs are assisting residents with toileting before and after meals. Nursing staff to be in-serviced on ensuring resident's extremities remain inside the wheel chair when propelling residents through door ways and around room to ensure the risk for skin tears is reduced. Nursing staff to also be in-serviced on utilizing additional staff when needed to help assist with a transfer if a resident is requiring more help than usual that day. Alzheimer's Care Director/designee to do rounds every day x 90 days then 3 times weekly x 90 days to ensure activities are being completed as scheduled and that residents are attending activities. UM/designee</p>		

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	<p>The record indicated that on 03-26-14 at 9:15 p.m., the resident was found on the floor on the back in hallway. The resident sustained a hematoma to the back of head which measured 4.0 by 4.5 cm.</p> <p>A subsequent notation dated 05-20-14 at 10:30 a.m., indicated the resident was found on the floor in the den. "Staff heard a thud and found resident sitting on floor in front of chair."</p> <p>The record contained documentation the nursing staff requested on 05-23-14 to the physician that "the resident's family requested her to be seen and evaluated by PT [physical therapy] due to increased falls and unsteady gait." The physician responded on 05-23-14 and agreed the resident could be evaluated by the therapy staff.</p> <p>On 06-17-14 at 1:15 p.m., the resident had fallen and was laying on her left side in hallway.</p> <p>A progress note dated 06-20-14 at 3:30 p.m., indicated the resident was found on the floor in the den sitting between the shelf and another resident's wheelchair. The resident was sent to the local area hospital for evaluation and treatment.</p>		<p>to round every day x 6 months to ensure licensed nursing staff is available on halls when CNAs are toileting residents before and after meals. UM/designee to also round every day x 6 months to observe that residents are being propelled safely in their wheel chairs by staff so as to reduce the risk of bumping their extremities and obtaining a skin tear. DCE/designee to watch CNAs transfer resident to ensure CNA is performing transfer safely. These audits to be completed 3 times weekly x 90 days then 1 time weekly x 90 days.</p>	

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	<p>The resident was assessed with a broken hip.</p> <p>The resident was readmitted to the facility and once again fell to the floor. The progress notes, dated 07-08-14 at 2:24 p.m., indicated "resident was trying to climb out of wheelchair while sitting at dining room table. CNA [certified nurses aide] removed resident to hallway when CNA turned to go get foot pedals for chair resident flipped back in chair. Resident has tip bars but they failed to work."</p> <p>During an interview on 07-25-14 at 1:30 p.m., the Unit Manager indicated the resident did not receive the physical therapy evaluation as directed by the physician on 05-23-14. The Unit Manager indicated the "therapy staff missed it but caught it in June." When interviewed about the date the resident was evaluated by physical therapy in June (2014), the Unit Manager indicated the resident was evaluated on 06-19-14 and the following day she fell and fractured her hip." The therapy notes dated 06-10-14 indicated "precautions indicated low endurance - needs frequent rests, balance precautions."</p> <p>The facility failed to provide interventions to alert the staff of the</p>			

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	<p>resident's unassisted attempts at ambulation or moving from surface to surface.</p> <p>2. The record for Resident "B" was reviewed on 07-23-14 at 12:00 p.m. Diagnoses included, but were not limited to dementia, colon cancer stage four, blindness in the right eye, syncope, hypertension and a fall risk. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's Minimum Data Set (MDS) assessment dated 04-07-14 indicated the resident was cognitively impaired, frequently incontinent of bladder always incontinent of bowel and was not steady, and only able to stabilize with human assistance in the areas of moving from seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfer.</p> <p>The record indicated the resident had a fall on 07-07-14 at 4:32 a.m. The progress note indicated the resident was "found sitting on buttocks on floor in doorway of bathroom facing room - stating she had gone to the bathroom. Wheelchair was at bedside - bed was in low position with matt at bedside - call light was not on. Resident <sic> has</p>			

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	<p>poor safety awareness/judgement for self - forgets to use call light for assist - wears brief and is generally incontinent."</p> <p>During an interview on 07-25-14 at 9:30 a.m., the Unit Manager indicated this was the fall which resulted in a fractured ankle.</p> <p>The resident was transported to the local area hospital for evaluation and treatment, and returned to the facility on 07-10-14 with a cast to the lower leg.</p> <p>Review of the resident's MDS assessment, dated 07-17-14, indicated the resident had a decline in transfer, bed mobility ambulation, toileting and continued to have problems with balance in the areas of moving from a seated to standing position, moving on and off toilet and surface to surface transfer.</p> <p>Further review of the progress notes dated 07-10-13 at 9:00 p.m., indicated the resident fell "forward out of wheelchair bumping area just immediately above left eyebrow causing superficial skin tear measuring 2.5 cm [centimeters] in length with slight bleeding - hematoma surfaced almost immediately about dime size immediately above left eyebrow, slight bleeding occurred for short time. Resident has dx. [diagnosis] of</p>			

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	<p>Alzheimer's disease and has poor safety awareness for self."</p> <p>The progress notes indicated the resident had two additional falls since she was readmitted to the facility after having sustained a fractured ankle. The resident was found on the floor of another resident's room on 07-19-14 at 2:35 p.m., and then again on 07-21-14 at 6:15 p.m., when staff found resident sitting on the bathroom floor with her w/c (wheelchair) behind her. A small reddened area was present to right side of mid back.</p> <p>The facility failed to provide supervision to prevent accidents or interventions to alert the staff of the resident's unassisted attempts at ambulation or toileting.</p> <p>During an interview, a concerned family member indicated she was not satisfied with the wheelchair positioning of the resident and felt as long as the resident had "one leg dangling while she was seated in the wheelchair, she would continue to make attempts to ambulate or stand up on her own while the fracture was healing."</p> <p>3. The record for Resident "F" was reviewed on 07-25-14 at 1:15 p.m. Diagnoses included, but were not limited to, dementia, anemia, psychotic disorder</p>			

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	<p>with hallucinations, muscle weakness and identified as legally blind. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS assessment, dated 04-23-14 indicated the resident had severe cognitive impairment, and was not steady, and only able to stabilize with human assistance in the areas of moving from seated to standing position, walking, turning around, moving on and off the toilet and surface to surface transfer.</p> <p>The resident's care plans indicated the resident was at risk for falls and fall related injury r/t (related to) impaired cognition, visual impairment, impaired mobility d/t (due to) recent hip fracture and surgical repair. The record further indicated the visual impairment referred to macular degeneration and could only see shadows against a contrasting background and required extensive assistance with bed mobility, transfers, toileting, dressing, grooming, personal hygiene/t impaired cognition, loss of vision, decline in mobility and overall function.</p> <p>A review of the progress notes indicated the resident fell on 05-12-14 at 2:05 p.m. - "found on floor in room near</p>			

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	<p>bathroom." This fall resulted in a fractured hip.</p> <p>The resident was transferred to the local area hospital for evaluation and treatment and returned to the facility.</p> <p>Continued review of the Progress notes indicated the resident was found on the floor on 06-03-14 at 1:54 p.m. - "in front of wheelchair." The resident indicated to the facility staff she had to "go to the bathroom." The record indicated the resident sustained a skin tear to the right shin which measured 2.0 cm by 0.4 cm.</p> <p>On 06-16-14 at 4:20 p.m., the resident was noted to be sitting at the dining room table and when attempted to sit back down in wheelchair went backwards and the resident fell to floor landing on buttocks hitting her head on the door. The wheelchair was not in a locked position.</p> <p>On 06-29-14 at 1:17 a.m., the resident was found on the floor in bathroom - fell after using restroom and slipping in urine. The resident indicated she hit her head.</p> <p>The record indicated on 07-21-14 at 5:20 p.m., the resident was found on the floor in the doorway to her room.</p>			

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	<p>The facility failed to provide interventions to alert the staff of the resident's unassisted attempts at ambulation, toileting or ensuring the wheelchair was in the locked position.</p> <p>4. The record for Resident "I" was reviewed on 07-24-14 at 1:55 p.m. Diagnoses included, but were not limited to, senile dementia, depressive disorder, hypertension and edema. These diagnoses remained current at the time of the record review.</p> <p>A review of the MDS assessment dated 05-09-14 indicated the resident had severe cognitive impairment and required the assistance of two plus staff members while transferring.</p> <p>During an interview on 07-23-14 a concerned family member indicated her mother had a significant skin tear on her right arm. The concerned family member indicated that when she came to visit, the resident kept repeating that her right arm hurt. The family member then indicated she pulled back the covers and discovered bright red blood on her mother's white sweater. She then indicated as she rolled back the sleeve of the sweater she could see the extent of the injury. She reported this to the</p>			

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	<p>administrator, who began an investigation.</p> <p>A review of the facility investigation report indicated two CNA's were interviewed. CNA #7 indicated she "got [name of resident] up and in her wheelchair and that she had put the sweater on her starting with the left arm and then her right arm."</p> <p>CNA #8 indicated she transported the resident back to her room after the resident had completed breakfast. The CNA indicated she did bump the resident's wheelchair on the dresser during the transport and then transferred the resident to her bed by standing her and pivoting her."</p> <p>The CNA's failed to ensure the resident was transferred with the appropriate numbers of staff members in attendance and failed to ensure the resident was not bumped into inanimate objects during transport which could have led to the skin tear.</p> <p>A review of the record indicated the skin tear measured 5.0 cm by 1.0 cm and required physician intervention/treatment in order for the area to heal</p> <p>This Federal tag relates to Complaint</p>						

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F000425 SS=D	<p>IN00152546.</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</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, 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 available to the residents, in that when a resident was admitted to the facility after a lengthy hospitalization, the facility failed to provide medications in a timely manner for 2 of 3 residents sampled for medications availability in a sample of</p>	F000425	Both Res "A" and Res "C" have their medications available to them. All residents who have been admitted to the facility in past 30 days have been reviewed to ensure they have all their medications available to them. The physician of any resident who was identified to have had a delay in receiving their medications	08/18/2014

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	<p>10. (Resident's "A" and "C").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 07-23-14 at 10:45 a.m. Diagnoses included, but were not limited to, ESRD (End Stage Renal Disease), convulsions, hypertension, pain, cerebral vascular accident, coagulation deficits, diabetes mellitus and edema. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 07-11-14 at 6:00 p.m.</p> <p>A review of a hospital handwritten note, dated 07-11-14 indicated the resident was accepted by the facility on 07-11-14 at 10:00 a.m., and then at 10:39 a.m., "Medication orders faxed to Golden Living, 12:25 p.m. Additional orders faxed to SNF [skilled nursing facility]."</p> <p>Although the physician orders were received at the facility at 10:00 a.m., the Unit Manager indicated the physician orders were not faxed to the pharmacy at that time, because "sometimes once a resident is discharged from the hospital, the orders occasionally change."</p> <p>Upon admission to the facility, the resident arrived with the following</p>		<p>upon admission has been notified of that delay. Licensed nursing staff to be in-serviced on proper procedure for notifying pharmacy of new admissions. When a resident is admitted to the facility the nurse will fax the residents orders to pharmacy and will then call the pharmacy to ensure they have received the orders and are aware this is a new admission. The nurse will document in the nurses notes that the orders have been faxed and that the pharmacy has been called. If the resident's medications are not available within 4 hours of the time pharmacy was notified of the new orders then the nurse will need to call and follow up with the pharmacy as to why they are not available. The nurse will also need to notify the physician and document in the nurses notes that the pharmacy and the physician have been notified. Nursing staff also in-serviced on ensuring that when they receive orders for a new admission they are reviewing to ensure all pages of meds are included. If they feel there are any pages that are missing with possible med orders then they need to notify the transferring facility of their concerns and also the physician if needed. UM/designee to audit all new admissions to ensure they received their medications timely and that the physician was notified if there was a delay. UM/designee to also review</p>				

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	<p>orders:</p> <p>"Accu-checks [blood test to determine the blood sugar level in the resident] BID [two times a day] related to Diabetes, Miconazole Barrier Cream, Protein powder two times a day, Amlodipine Besylate Tablet 10 mg [milligrams] [a medication to control blood pressure], Bisacodyl Suppository 10 mg one time a day - 1 day on and 1 days <sic> off for constipaion <sic>, Coumadin [a blood thinner medication] Tablet 7.5 mg one tablet by mouth in the afternoon, Granulex Aerosol Solution 0.12-788-87 mg/gm [milligrams per gram] topically every evening and night shift for portect <sic> skin, Labetalol HCL 200 mg [a medication for blood pressure control] 200 mg two times a day, Lyrica Capsule 50 mg by mouth at bedtime [a medication to control pain], Metoclopramide HCL [a medication to aide in reflux disease] 5 mg before meals, Nephro-Vite 0.8 mg one by mouth one time a day related to End Stage Renal Disease [a supplement] Synthroid 50 mcg [micrograms] in the morning [a medication to aide in thyroid therapy]."</p> <p>A review of the nursing progress notes, dated 07-11-14 through 07-15-14 indicated the following:</p>		<p>admitting orders for all new admissions to ensure there was no missing pages that may have contained medication orders and that the transferring facility was contacted if there was any concerns. These audits will be conducted every day x 90 days, then 3 x weekly x 90 days, then weekly thereafter. The results of these audits will be reviewed at QAPI x 6 months to track for any trends. If any trends identified then the audits will be completed based on QAPI recommendations. If no trends identified then will review on a PRN basis.</p>		

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	<p>"07-11-14 at 20:19 [8:19 p.m.] - New Admit - Res. arrived to the facility at 6:28 p.m. All meds faxed to [name of pharmacy] at 20:06 [8:06 p.m.] and face sheet for medication delivery"</p> <p>"07-12-14 at 10:35 a.m. Medication no <sic> available. Pharmacy called times 2."</p> <p>"07-12-14 13:37 [1:37 p.m.] Late Entry note - at 8:45 a.m. unable to get residents meds from ADU [automatic medication delivery system]. Called Alexia Rx, stated to them that I was unable to get meds from ADU, pharmacy technician stated that was because there was no call to advise them of a new resident. Stated the orders were right there beside her and she hadn't started them yet, but will start them. Will send them on the next run."</p> <p>"07-12-14 at 21:32 [9:32 p.m.] medication not available from the pharmacy."</p> <p>"07-12-14 at 21:33 [9:33 p.m.] medications not availed from the pharmacy."</p> <p>"07-14-14 at 10:10 a.m. NP [nurse practitioner] in to see resident, spoke with [family member] received multiple new orders."</p>				

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	<p>Further review of the progress notes indicated that on 07-12-14 at 23:04 [11:04 p.m.] indicated, "[Family member] requested SS [sliding scale] order for glucose control. Orders received from NP [nurse practitioner] for SS and Accuchecks QID [four times a day]."</p> <p>A review of the Electronic Medication Record on 07-24-14 at 10:30 a.m. revealed the following:</p> <p>Amlodipine Besylate 10 mg not administered to the resident until 07-13-14 at 9:00 a.m., Bisacodyl Suppository 10 mg not administered to the resident until 07-12-14 at 5:00 p.m., Coumadin 7.5 mg was not administered until 07-12-14 at 5:00 p.m., Famotidine 20 mg not administered until 07-15-14 at 2100 [9:00 p.m.], Levothyroxine 50 mcg not administered until 07-13-14 at 6:00 a.m., Methlnslytrexone Bromide 12 mg/0.6 ml [milliliters] until 07-15-14 at 9:00 a.m., Nephro-Vite tablet 0.8 mg was not administered until 07-13-14, Miralax 17 grams was not administered until 07-15-14.</p> <p>The Electronic Medication Record indicated that the resident did not receive the Labetalol 200 mg until 07-12-14 at</p>			

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	<p>9:00 p.m., Protein Powder 1 scoop per g-tube [gastrostomy feeding tube] was not available for the resident until 2100 [9:00 p.m.] on 07-12-14, Senna Tablet 8.6 mg was not available for the resident until 07-16-14 at 9:00 a.m., Metoclopramide HCL 5 mg was not available for the resident until 1630 [4:30 p.m.] on 07-12-14,</p> <p>During an interview on 07-24-14 at 10:00 a.m., the Unit Manager indicated that although the resident brought a listing of medications from the hospital, the orders that were originally faxed to the facility, were missing "page two" and that the nursing staff didn't realize a page was missing.</p> <p>The Unit Manager indicated she immediately called the hospital on Monday 07-14-14 and finally received "page two" on 07-15-14 at 11:57 a.m. A progress note also dated 07-15-14 at 13:58 [1:58 p.m.], indicated "Received Rx [prescription orders] from [name of hospital] with page 2 of admission orders attached. Orders noted and MD [medical doctor] and residents [family member] notified of omission of orders upon admissions."</p> <p>A review of the faxed orders received at the facility on 07-11-14 clearly indicated</p>						

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	<p>at the bottom of each page "1 of 4," "2 of 4," "3 of 4," and "4 of 4."</p> <p>A review of the "page two" physician orders included the following medications: "NovoLog SQ [subcutaneous] BID [two times a day], Folic acid [a supplement] daily, Pepcid 20 mg, Senokot [a stool softener] 2 - two times a day, Miralax [a medication used in the treatment of constipation], Relistro Sq [a medication to aide in elimination] every 48 hours."</p> <p>2. The record for Resident "C" was reviewed on 07-23-14 at 11:10 p.m. Diagnoses included, but were not limited to, late effect cerebrovascular accident, constipation, anxiety, urinary retention, hypothyroidism, hemiplegia, dysphagia, neurogenic bladder and diabetes mellitus. These diagnoses remained current at the time of the record review. Resident "C" was admitted to the facility on 07-18-14.</p> <p>The record indicated the resident had admission physician orders for Lidocaine Patch 5 % - apply to posterior neck incision topically two times a day for incisional pain on in a.m. and off hs (bedtime). A review of the Electronic Medical Record indicated the resident did not receive the pain patch at 9:00 a.m. as prescribed. In addition the resident had a</p>			

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	<p>physician order for Norco Tablet [a controlled analgesic medication] 10-325 mg one tablet by mouth five times a day for chronic pain. The Electronic Medical Record indicated the pain medication was not administered because it was unavailable and eventually administered on 07-19-14 at 1300 (1:00 p.m.). An additional topically pain patch, Flector 1.3 % - which directed the nursing staff to apply at 6:00 a.m. and then again at 9:00 p.m., but the resident did not receive the medication until 07-20-14 at 9:00 p.m.</p> <p>A review of the Progress Notes indicated the following:</p> <p>"07-18-14 at 23:41 [11:41 p.m.] Resident was returned to facility by transportation for [name of local area hospital] by transport and orders."</p> <p>"07-18-14 23:43 [11:43 p.m.] at 20:00 [8:00 p.m.] MD called and medication orders clarified."</p> <p>"07-19-14 7:00 a.m. - Medications unavailable from pharmacy."</p> <p>"07-19-14 at 13:58 [1:58 p.m.] Pharmacy notified of medications times three, able to get medications at 1:00 p.m. after calling the pharmacy 4 times."</p>			

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	<p>"07-19-14 at 14:26 [2:26 p.m.] Lidocaine patch unavailable. pharmacy notified. Stated it would be on the next run."</p> <p>"07-19-14 at 14:31 [2:31 p.m.] Flector patch unavailable. Pharmacy stated it would be on next run."</p> <p>3. The Consultant Pharmacist provided a "Timeline" of the events with the medications/delivery for Resident "A."</p> <p>"07-11-14 8:33 p.m. - face sheet and orders received via fax [facsimile].</p> <p>07-12-14 8:59 a.m. - received a phone call from [name of nursing staff] requesting the ADU [an automated medication delivery system] meds. [medications] be entered.</p> <p>07-12-14 approx. [approximately] 9:35 a.m. ADU meds were entered by technician.</p> <p>07-12-14 approx. 10:55 a.m. ADU meds verified by pharmacist (would be available at the kiosk at this time as NEW 8 of the patients meds. are available in the ADU - 6 others are available in the EMC [emergency drug container].</p>			

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	<p>07-12-14 all remaining meds were delivered with normal delivery which left the pharmacy at 5 p.m. (Saturday).</p> <p>07-12-14 9:20 p.m. we received a signed packing slip via fax."</p> <p>The 'timeline" further indicated they did "not show any records from our after hours service that the facility called regarding this patient (they answer the phones from 9 p.m. to 8:30 a.m.)"</p> <p>4. During an interview on 07-24-14 at 12:15 p.m., the consultant pharmacist indicated the facility nursing staff needed to not only fax (facsimile) the physician orders to the pharmacy but also needed to call the pharmacy as outlined in the policy.</p> <p>The consultant pharmacist further indicated the above was especially important when a resident entered the facility after the "cut off" time.</p> <p>5. A review of the "Pharmacy Delivery Schedule and Cut off Times," on 07-23-14 at 10:00 a.m., and dated as revised 01-16-14, indicated the following:</p> <p>"Policy - A schedule of pharmacy hours, delivery times, and routine order cut off</p>						

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	<p>times is established and posted on a Quick Reference Guide located at each nursing station in the Facility."</p> <p>"Delivery Schedule - Punch cards and bulk items - Mon. [Monday] - Fri. [Friday] 2:00 p.m., 9:00 p.m. departure from Pharmacy. Sat. [Saturday] - Sun. [Sunday] 5:00 p.m. departure from the Pharmacy."</p> <p>"Medications from First Dose Pharmacy - Target to be delivered to each Facility within 4 hours after a confirmed order is received by the pharmacy."</p> <p>"NEW ORDERS [bold type and underscored]: Must be faxed by: Monday - Friday 12:00 p.m. Cut-off - 1st Run (2:00 p.m.), 6:30 p.m. Cut - off 2nd Run (9:00 p.m.)."</p> <p>"The orders faxed after the cutoff will not be processed until the next scheduled delivery. **Facility must call the pharmacy with any exceptions, stats, new admissions after cut off times .**"</p> <p>6. A review of an additional pharmacy policy on 07-23-14 at 10:00 a.m., and dated as revised on 01-16-14, and titled "Pharmacy Contacts and Hours of Operation," indicated the following:</p>			

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	<p>"On call services are available during all non-business hours and all holidays: M-F [Monday - Friday] 9:00 p.m. - 8:30 a.m., Sat. [Saturday] 3:00 p.m. - 8:30 a.m., Sun. [Sunday] 3:00 p.m. - 8:30 a.m."</p> <p>"After hours Phone Tree Process: In order for us to best assist your needs during non-business hours, please allow the On-Call Pharmacist at least 30 minutes to respond prior to contacting the next listed employee on the call tree. The following numbers are available if your needs have not been met. Option 1 - On Call Pharmacist, then the Pharmacy Service Technician, the Pharmacy Supervisor and then the General Manager."</p> <p>7. During an interview on 07-23-14 at 12:30 p.m., the concerned family member for Resident "A" indicated the resident should not have gone "days without getting the medications she needed and the nursing staff should have realized a page was missing when they first received the orders from the hospital.</p> <p>"</p> <p>This Federal tag relates to Complaint IN00152546.</p> <p>3.1-25(e)(2) 3.1-25(g)(2)</p>			

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

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