STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155248		05/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVING CENTER-BRENTWOOD	30 E CHANDLER AVE EVANSVILLE, IN 47713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00197285, Complaint IN00199065, Complaint IN00199856, and Complaint IN00200890. Complaint IN00197285 - Unsubstantiated, due to lack of evidence. Complaint IN00199065 - Unsubstantiated, due to lack of evidence. Complaint IN00199856 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F425. Complaint IN00200890 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282. Survey dates: May 24, 25, and 26, 2016 Facility number: 000152 Provider number: 155248 AIM number: 100267510 Census bed type: SNF/NF: 81 Total: 81 Census payor type:	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	Medicare: 8 Medicaid: 57 Other: 16 Total: 81 Sample: 16 Quality review completed by #02748 on May 27, 2016.			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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	Based on interview and record review, the facility failed to ensure an intravenous (IV) medication was administered as ordered by the physician, for 1 of 10 residents reviewed for medication orders, in a sample of 16. Resident C Findings include: The closed clinical record of Resident C was reviewed on 5/25/16 at 11:30 A.M. Documentation indicated the resident returned to the facility from the hospital on 4/6/16. Diagnoses included, but were not limited to, pneumonia. A Physician's order, dated 4/6/16, indicated, "Vancomycin [an antibiotic]...Use 1000 mg intravenously every 36 hours for Pneumonia for 7 days...." The resident's Medication Administration Record (MAR), dated April 2016, indicated the resident received the Vancomycin on 4/8/16 at 2:47 A.M., and on 4/9/16 at 3:15 P.M. On 5/26/16 at 9:15 A.M. during an interview with the Director of Nursing (DON), he indicated he was unaware of the medication error. He indicated he was	F 0282	1 Unable to correct 2 Audit of IV usage and compliance of physician's orders completed by DNS or designee 3 Nurses in-serviced on correct way to enter prescriptions into electronic MARS system New Orders reviewed by DNS or designee X5 week Charge Nurse will alert DNS if medication not delivered timely. Electronic MARS, for existing residents will be reviewed monthly X3 and Quarterly X3 by DNS or designee. 4 Audits reviewed in QAPI monthly to identify trends Actions plans developed, as needed	06/25/2016

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	unsure if it was a "software glitch," but that the nurse should have checked the order prior to administering the medication. On 5/26/16 at 9:50 A.M., the DON provided the current facility policy on "Administration Procedures for All Medications," revised August 2014. The policy included: "Policy, To administer medications in a safe and effective manner. Procedures...Review 5 Rights (3) times...Check MAR/TAR [Treatment Administration Record] for order...Check the label against the order on the MAR...After the dose has been prepared...." This Federal tag relates to Complaint IN00200890. 3.1-35(g)(2)			

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F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure a pain assessment was performed upon a newly admitted resident, with a diagnosis of terminal cancer, and failed to obtain pain medication timely, for 1 of 5 residents reviewed for pain management, in a sample of 16. Resident A Findings include: The closed clinical record of Resident A	F 0309	1. Unable to correct 2. Resident's records reviewed for pain rating documentation and pain medication available and administered, as needed. 3. Nursing in-serviced on completing Pain Assessment on residents appearing to be having pain issues MARS audited to ensure residents are receiving pain medication, and pain level scores are being recorded Electronic MARS audited monthly X3 and Quarterly X3 by DNS or designee.	06/25/2016

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	was reviewed on 5/24/16 at 3:00 P.M. Diagnoses included, but were not limited to, malignant neoplasm lower lobe of lung. A hospital discharge summary, dated 5/5/16, indicated, "...Diagnosis, Intractable [severe, constant] neuropathic pain of left lower extremity, Bone metastases, Pain due to malignant neoplasm metastatic to bone...Pt [patient] has continued to decline over the last few days...pain fairly well controlled...I have added Roxinol (SL [sublingual] morphine) as well as liquid Ativan for her comfort...." Facility admission physician orders, dated 5/5/16, included: "Dilaudid 2 mg, Give 2 mg by mouth every 4 hours as needed for pain, Morphine Sulfate solution 20 mg/ml, Give 1.5 ml by mouth every 2 hours as needed for pain, MS Contin Extended Release 30 mg, Give 3 tablets by mouth every 12 hours...." A nursing admission form, dated 5/5/16 at 3:25 P.M., indicated, "...Pain evident: Yes, Alert, Needs assist with decisions at this time...Pain, Numeric Rating Scale [left blank], Pain Rating Score [left blank], Verbal Descriptor Scale [left blank], Location of Pain [left blank], Characteristics of Pain [left blank],		4. Audits reviewed in QAPI to identify trends Action plans developed, as needed	

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	Frequency With Which Resident Complaint or Shows Evidence of Pain [left blank], Current pain treatment plan [left blank], Date/Time of last dose given [left blank]...." A pre-printed care plan, undated and unsigned, included, "Problem, Pain and pain symptoms risks related to:...Interventions: 1. Assess and establish level of pain on numeric scale/assessment tool. 2. Implement pain control strategies of: [left blank]...Don't wait for resident to request pain medication but offer it to the resident at frequencies indicated in the physician order...." The first Progress Note, dated 5/5/16 at 4:26 P.M., indicated, "New admit, family requesting a phone, work order placed...." Progress Notes continued: 5/5/16 at 9:02 P.M.: "MS Contin Tablet Extended Release 30 mg Give 3 tablet by mouth every 12 hours...." 5/5/16 at 11:30 P.M.: "Arrived for shift, resident sister at nurses station states resident was in severe pain an needed something right now. Assessment of resident noted resident grimacing and voicing pain. Attempt to remove pain medication from EMC [Emergency			

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	Medical Cart] non available at this time, call placed to pharmacy." 5/6/16 at 12:00 A.M.: "Call placed to pharmacy again unable to obtain prn [as needed] pain medication for resident, suggest to call MD to see if we could get another medication until medication arrive [sic] on delivery." 5/6/16 at 12:21 A.M.: "Call placed to MD, request of medication situation, and that pharmacy suggest to give one time order to give med from EMC until medications arrived...." 5/6/16 at 12:30 A.M.: "Call placed to DON [Director of Nursing] informed of situation, stated we have informed sister that medication would not be here until around 3 am, will call MD to send out to send to [sic] er for pain management." 5/6/16 at 1:00 A.M.: "Order received to send to [name of hospital] er for pain management." The resident's Medication Administration Record (MAR) indicated the resident received Morphine Sulfate 10 mg at 11:44 P.M. as a "one time only" medication. On 5/25/16 at 1:10 P.M., during an			

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	interview with the Director of Nursing (DON) and Administrator, the DON indicated the nurse who admitted the resident on 5/5/16 was a staffing agency nurse. The DON indicated the staffing agency had been notified that the facility no longer wanted to utilize this nurse. The DON indicated that as soon as he was notified of the situation, he suggested that the resident be sent to the ER. The Administrator indicated at that time that this incident was reported to the Indiana State Department of Health (ISDH), and that the facility had inserviced staff. The Administrator indicated that the facility would also not have agency nurses performing admissions. The Administrator provided an ISDH reportable document regarding Resident A. The document included: "Resident admitted in pain. Charge Nurse failed to complete an assessment of the resident's pain. While awaiting a delivery of the resident's medication from the pharmacy, there was a 4 hour delay in providing medication through the EDK [Emergency Drug Kit]. Resident was discharged to the hospital, 6 hours after placement, due to facilities [sic] inability to control resident's pain...Preventive Measures			

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	Taken...Director of Nursing Services in-serviced nurses on proper pain assessment and documentation...." On 5/25/16 at 2:15 P.M., the DON provided the current facility policy on "Pain Assessment and Management," dated 2/5/15. The policy included: "It is the policy of [name of corporation] to promptly assess patient/resident pain levels and to provide relief of symptoms whenever feasible...Patients/residents will be assessed for pain utilizing standardized pain scales and evaluations upon admission (within 24 hours)...and as needed, based on their exhibiting symptoms of pain...An IPOC [interdisciplinary plan of care] or care plan will be initiated and reflect pain management interventions...Documentation relative to pain management may be reflected in any or all of the following: the eMAR, the care plan, evaluations, the Minimum Data Set, and/or interdisciplinary progress notes...." This Federal tag relates to Complaint IN00199856. 3.1-37(a)			

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F 0425 SS=D Bldg. 00	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. 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. 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 the pharmacy obtained pain medication timely for 1 of 5 residents reviewed for pain management, in a sample of 16. Resident A	F 0425	1. Unable to correct 2. Reviewed physician's orders to ensure pain medication was available and administered timely 3. Nurses will be in-serviced on ordering medications from pharmacy and when to require medications from the back up pharmacy New orders reviewed	06/25/2016

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	Findings include: The closed clinical record of Resident A was reviewed on 5/24/16 at 3:00 P.M. Diagnoses included, but were not limited to, malignant neoplasm lower lobe of lung. A hospital discharge summary, dated 5/5/16, indicated, "...Diagnosis, Intractable [severe, constant] neuropathic pain of left lower extremity, Bone metastases, Pain due to malignant neoplasm metastatic to bone...Pt [patient] has continued to decline over the last few days...pain fairly well controlled...I have added Roxinol (SL [sublingual] morphine) as well as liquid Ativan for her comfort...." Facility admission physician orders, dated 5/5/16, included: "Dilaudid 2 mg, Give 2 mg by mouth every 4 hours as needed for pain, Morphine Sulfate solution 20 mg/ml, Give 1.5 ml by mouth every 2 hours as needed for pain, MS Contin Extended Release 30 mg, Give 3 tablets by mouth every 12 hours...." Progress Notes included: 5/5/16 at 9:02 P.M.: "MS Contin Tablet Extended Release 30 mg Give 3 tablet by mouth every 12 hours...."		by DNS or designee X5 week Charge Nurse will alert DNS if medications is not delivered timely. Electronic MARS, for existing residents will be reviewed monthly X3 and quarterly X3 by DNS or designee Communications and documentation received by pharmacy reviewed by DNS or designee, X5 week, to ensure residents receiving medication in a timely manner 4. Audits reviewed in QAPI monthly to identify trends Action plans developed, as needed	

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	5/5/16 at 11:30 P.M.: "Arrived for shift, resident sister at nurses station states resident was in severe pain an needed something right now. Assessment of resident noted resident grimacing and voicing pain. Attempt to remove pain medication from EMC [Emergency Medical Cart] non available at this time, call placed to pharmacy." 5/6/16 at 12:00 A.M.: "Call placed to pharmacy again unable to obtain prn [as needed] pain medication for resident, suggest to call MD to see if we could get another medication until medication arrive [sic] on delivery." 5/6/16 at 12:21 A.M.: "Call placed to MD, request of medication situation, and that pharmacy suggest to give one time order to give med from EMC until medications arrived...." 5/6/16 at 12:30 A.M.: "Call placed to DON [Director of Nursing] informed of situation, stated we have informed sister that medication would not be here until around 3 am, will call MD to send out to send to [sic] er for pain management." 5/6/16 at 1:00 A.M.: "Order received to send to [name of hospital] er for pain management."			

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	On 5/25/16 at 1:10 P.M., during an interview with the Director of Nursing (DON) and Administrator, the DON indicated the nurse who admitted the resident on 5/5/16 was a staffing agency nurse. The DON indicated the prescriptions for the pain medication had been faxed to the pharmacy, but had not been marked as "STAT." The DON indicated since this incident, all new admissions will have the physician orders that are sent to the pharmacy marked as "STAT." The Administrator indicated he had heard the Marketing Director speak to the pharmacy at the time of the resident's admission, and the Marketing Director told the pharmacy that the facility needed the medications "right now." The Administrator indicated since the word "STAT" was not used, the pharmacy started the process of routine medication delivery. The Administrator indicated that the pharmacy was located in Indianapolis, and so it would take 4 hours for medications to be delivered if they were ordered "STAT." He indicated there was a local back up pharmacy, but since the medications had already been processed, they could not have a back up pharmacy provide the medications. The Administrator indicated the resident's			

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	medications would not have been delivered until approximately 3:30 A.M. on 5/6/16, and so the resident was transferred to the hospital for pain management. The Administrator provided an Indiana State Department of Health reportable document regarding Resident A. The document included: "Resident admitted in pain...While awaiting a delivery of the resident's medication from the pharmacy, there was a 4 hour delay in providing medication through the EDK [Emergency Drug Kit]. Resident was discharged to the hospital, 6 hours after placement, due to facilities [sic] inability to control resident's pain...." On 5/25/16 at 2:25 P.M., the Administrator provided the current facility policy on "Unavailable Medications," dated August 2014. The policy included: "...The facility must make every effort to ensure that medications are available to meet the needs of each resident. Procedures: The pharmacy staff shall: 1. Call or notify nursing staff that the ordered product (s) is/are unavailable...Suggest alternative, comparable drug(s) and dosage of drug(s) that is/are available...." This Federal tag relates to Complaint			

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	IN00199856. 3.1-25(a)			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155248	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/26/2016

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