STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155762	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 09/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST PARK HEALTH CAMPUS	2401 S L ST RICHMOND, IN 47374

(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
F000000	This visit was for the Investigation of Complaint IN00155060. Complaint IN00155060-Substantiated. Federal/State deficiencies related to the allegations are cited at F-246, F-282, F-309, & F-318. Unrelated deficiencies are cited. Survey dates: September 11, 12, 15, & 16, 2014. Facility number: 011387 Provider number: 155762 AIM number: 200853180 Survey team: Angel Tomlinson, RN, TC Barbara Gray, RN Census bed type: SNF: 35 SNF/NF: 26 Residential: 20 Total: 81 Census payor type: Medicare: 27 Medicaid: 21 Other: 13 Total: 61	F000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00155060) Survey on September 16, 2014. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

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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	Sample: 11 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 23, 2014 by Cheryl Fielden, RN.			
F000246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on interview and record review, the facility failed to answer resident's call lights and provide care timely, for 3 of 8 residents reviewed for call lights, in the total sample of 11. (Residents #H, #J, #K) Findings include: 1. On 9/11/14 at 3:45 p.m., Resident #H was observed seated upright in his wheelchair in his bedroom. He was receiving oxygen through a nasal cannula. A family member visiting	F000246	**F 246 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #H, #J, #K are confidential as part of the complaint survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All residents will be interviewed and / or observed to ensure compliance: Interview and / or observation to ensure staff answer resident's call lights and provide care timely.	10/16/2014

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	Resident #H indicated on 9/4/14, she had went to the nurse's station and requested assistance to clean Resident #H because he had soiled himself. She indicated the nurse had informed her they were very busy. She indicated after she went to the nurse's station a second time to request assistance she began cleaning Resident #H herself because he had feces on himself. She indicated a nurse came in to assist her approximately 30 minutes after her first request. On 9/15/14 at 12:30 p.m., another family member visiting Resident #H indicated on 9/7/14, Resident #H was "messy and had dried stool." She indicated the stool was old and dried. She indicated it "was upsetting." Resident #H's record was reviewed on 9/15/14 at 3:02 p.m. Diagnoses included but were not limited to, congestive heart failure, hypertension, coronary artery disease, osteoporosis and atrial fibrillation. Resident #H's admission Minimum Data Set (MDS) assessment dated 8/5/14, indicated he was severely impaired in his skills for daily decision making on his Brief Interview for Mental Status (BIMS) exam. He required extensive assistance of 1 person for bed mobility, transfer,		**Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Nursing Staff on the following: 1. Guideline for Answering Call Lights 2. Trilogy's E's To Successful Customer Service 3. Expectations of Excellence for CNA and Nurse 4. Job Description for CNA and Nurse **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Interview and / or observation to ensure staff answer resident's call lights and provide care timely. The results of the observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter, for further recommendations.	

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	dressing and toileting. He did not walk. 2. On 9/12/14 at 9:45 a.m., Resident #J was observed lying in bed on his back with his head elevated approximately 30 degrees. He indicated for several years he has had blisters on his buttock and they hurt when he sat up in his wheelchair to long. He indicated when he requested to be transferred the average wait was approximately 45 minutes. He indicated he required 2 staff assistance to transfer with the use of a mechanical lift . On 9/12/14 at 4:55 p.m., a family member visiting Resident #J indicated Resident #J had blisters on his buttock that were vascular in nature and he has had them for several years. The visiting family member indicated Resident #J's back and buttock hurt him sometimes when he sat up in his wheelchair. Resident #J's record was reviewed on 9/16/14 at 9:30 a.m. Diagnoses included but were not limited to, renal insufficiency, anemia and atrial fibrillation. His admission MDS assessment dated 8/16/14, indicated he was cognitively intact in his skills for daily decision making on his BIMS exam. He required extensive assistance of 2 persons for bed mobility, transfer			

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	and dressing. He required extensive assist of 1 person for personal hygiene. He did not walk. 3. On 9/16/14 at 11:55 a.m., Resident #K was observed seated upright in her wheelchair. She indicated call lights were often not answered timely. She indicated on evening and night shift she sometimes had to wait up to 45 minutes for staff to respond. She indicated the problem was getting worse with staff not responding timely to call lights. She indicated some of the nurses would say they were busy and had other residents to care for. Resident #K's record was reviewed on 9/16/14 at 1:15 p.m. Diagnoses included but were not limited to, spinal stenosis, severe arthritis in both knees and shoulders, neuropathy, hypertension and anemia. Her quarterly MDS assessment dated 8/15/14, indicated she was cognitively intact in her skills for daily decision making on her BIMS exam. She required extensive assistance of 2 persons for bed mobility and toileting. She required extensive assistance of 1 person for transfer, dressing, personal hygiene and walking in her room. 4. Confidential interviews with staff indicated the following: On 9/12/14 at			

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	8:45 a.m., Staff #4 indicated there were not enough staff to give residents care timely. Staff #4 indicated some of the nurses didn't help with the resident's daily care. Staff #4 provided the following examples of residents not receiving timely care: Staff #4 indicated one day a resident requested assistance to get out of bed and it took 45 minutes before another staff member could assist in getting the resident up. Staff #4 indicated the resident required assistance of 2 staff with the use of a mechanical lift. Staff #4 indicated "this happens all the time." Staff #4 indicated placing residents on the toilet and not being able to help them off the toilet after they placed their call light on for 20 minutes or longer. On 9/16/14 at 10:40 a.m., Staff #5 indicated sometimes residents were having to wait 30 to 60 minutes to have their call lights answered. Staff #5 indicated there were only a couple of nurses who would assist with answering call lights, assisting residents on and off the toilet, and providing care. Staff #5 indicated it was a problem on all 3 shifts. On 9/16/14 at 12:02 p.m., Staff #6 indicated night shift needed more staff "because of the condition I find residents when I come in."			

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	A review of the "Resident Council Meeting Minutes" provided by the Life Enhancement Director on 9/16/14 at 1:56 p.m., indicated the following: 8/1/14 -"The residents voiced their concerns about the lack of assistance on all three shifts for 100 hall residents. Report was written up on Concern form and turned into appropriate department." 9/5/14 - "Residents reported the call light response is still slow. They feel they do not have enough help for 100 hall 2nd shift. Report is being written about concerns and is turned in to appropriate department/DHS (Director of Health Services)." This Federal tag relates to Complaint IN00155060. 3.1-3(v)(1)			
F000282 SS=D	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. Based on observation, interview and record review the facility failed to follow the physician order for oxygen administration of 2 liters nasal cannula for 1 of 3 residents reviewed for	F000282	**F 282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #F is confidential as part of complaint survey. **Identification of**	10/16/2014

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	respiratory care in a total sample of 11 (Resident #F). Finding include: During observation on 9/12/14 at 9:45 a.m., Resident #F was sitting in his recliner with oxygen on via nasal cannula, the oxygen flow rate was 3 liters. Interview with CNA #1 on 9/12/14 at 10:25 a.m., indicated she assisted Resident #F out of bed around 7:00 a.m. CNA #1 indicated Resident #F had his oxygen on in bed. CNA #1 indicated she did not change the flow rate of the resident's oxygen. CNA #1 indicated the flow rate of 3 liters was what the resident's oxygen was set on when she assisted him out of bed. Review of the record of Resident #F on 9/12/14 at 10:36 a.m. indicated the resident's diagnosis included, but were not limited to, chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment for Resident #F, dated 8/16/14, indicated the resident's BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact.		**other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will review all residents with ordered oxygen to ensure it is being administration as ordered by the MD. In addition, will review the documentation on the MAR and respiratory breathing treatment record (if applicable) to ensure the oxygen administration is documented as ordered by the MD. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following guideline: Administration Of Oxygen **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 5 times per week times 8 weeks, then weekly times 4 months to ensure compliance: 1. Residents with ordered oxygen to ensure it is being administered as ordered by the MD. 2. Documentation on the MAR and respiratory breathing treatment record (if applicable) to ensure the oxygen administration is documented as ordered by the MD. The results of the audit observations will be reported, reviewed and trended	

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	The physician recapitulation orders for Resident #F, dated September 2014, indicated the resident was ordered oxygen at 2 liters nasal cannula continuous for chronic pulmonary disease. The respiratory breathing treatment record for Resident #F indicated the following documentation: 9/6/14, 9/7/14, 9/8/14, 9/9/14, 9/10/14, 9/13/14, 9/14/14 and 9/15/14 the resident's oxygen liters were 3 liters. Interview with the Unit Manager on 9/12/14 at 10:38 a.m., indicated the procedure for ensuring resident's oxygen was administered as ordered by the physician was the nurse checked checked oxygen settings every shift. Interview with Resident #F on 9/12/14 at 11:30 a.m., indicated he had not changed his oxygen settings. Resident #F indicated the staff set his oxygen liters for him. This Federal tag relates to Complaint IN00155060. 3.1-35(g)(2)		for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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F000309 SS=D	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 observation, interview and record review the facility failed to assist dependent residents with repositioning resulting in residents remaining in the same position for up to 6 hours and 35 minutes for 2 of 7 residents reviewed for quality of care in a total sample of 11 (Resident #D and Resident #C). Findings included: 1.) During initial tour of the facility with LPN #3 on 9/11/14 at 10:35 a.m., LPN #3 indicated Resident #D required extensive assistance of staff for care. Resident #D was asleep in bed on her back and the head of the bed was elevated 30 degrees. LPN #3 indicated Resident #C was totally dependent on staff for care. During observation on 9/11/14 at 1:08 p.m., Resident #D was laying in bed on her back awake with the head of bed was elevated 30 degrees.	F000309	**F 309** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #D and #C are confidential as part of the complaint survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will observe all residents to ensure they assisted with repositioning during routine rounds. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or	10/16/2014

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	During observation and interview on 9/11/14 at 4:25 p.m., Resident #D was laying in bed on her back with the head of the bed elevated 30 degrees. Resident #D indicated she could not reposition herself in bed. Resident #D indicated she had been the same position for a long time and it caused her "bottom" to be sore. Resident #D indicated she fell and fractured her ankle and could not get out of the bed until her physician released her to get up. When queried if she was left in the same position in bed often, Resident #D indicated it does happen sometimes, but there were CNA's that would come in and reposition her with pillows. Resident #D indicated she did not feel it was anyone's fault that she was not repositioned, the staff were busy and with her left foot broke it was "just" the way it was. Resident #D indicated she attempted to move herself in bed "the best" she could. Resident #D indicated she had at least 12 more days she had to remain in bed before she would be able to get up. Interview with CNA #2 on 9/11/14 at 4:40 p.m., indicated she was caring for Resident #D. When queried if Resident #D was on a turning and repositioning schedule, CNA #2 indicated sometimes the staff would put pillows behind the resident's back.		designee will re-educate the nursing staff on the following guideline: Turning and Repositioning **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents are assisted with repositioning during routine rounds The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	Review of the record of Resident #D on 9/12/14 at 11:50 a.m., indicated the resident's diagnoses included, but were not limited to, depression, anxiety, hypertension, diabetes mellitus, arthritis and left ankle fracture. The physician order for Resident #D, dated 9/3/14 (no time) indicated the resident was ordered to be bed bound with the left ankle elevated above the heart at all times. The nursing admission assessment for Resident #D, dated 9/3/14, indicated the following: cognition alert and oriented, mobility- bed bound, bed mobility-extensive assistance of one to two staff, skin breakdown risk potential indicated the resident was at risk due to mobility impairment, incontinence, past history of skin breakdown and left ankle fracture with edema. The admission Minimum Data Set (MDS) assessment for Resident #D, dated 9/10/14, indicated the following: rejection of care- behavior did not occur, BIMS (Brief Interview for Mental Status) was a 15, with a range of 13-15, indicating the resident is cognitively intact, bed mobility- extensive assistance of two people, walk in room- did not			

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	occur, toilet use- extensive assistance of two people, urinary continence- frequently incontinent, bowel continence- always incontinent and the resident was at risk of developing a pressure ulcer. The care plan for Resident #D, dated 9/5/14, indicated the resident was on bed rest and needed assistance with repositioning. 2.) During observation on 9/12/14 at 9:40 a.m., Resident #C was laying in bed on her left side with a wedge cushion under her right side. During observation on 9/12/14 at 12:45 p.m., Resident #C was laying in bed on her left side with a wedge cushion under her right side. Interview with CNA #1 on 9/12/14 at 12:47 p.m., when queried what time Resident #C was scheduled to be turned and repositioned, CNA #1 indicated the resident probably needed turned and repositioned now. During observation on 9/12/14 at 3:20 p.m., Resident #C was laying in bed on her left side with a wedge cushion under her right side. Interview with CNA #2 at this time indicated she was caring for Resident #C. CNA #2 indicated she			

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	started work at 2:00 p.m. When queried what the system was to know when residents needed turned and repositioned, CNA #2 indicated first shift does not give an exact time when residents were last repositioned and she usually turned and repositioned residents around 3:30 p.m. CNA #2 indicated she was taught in CNA training residents needed repositioned and turned at least every two hours. Review of the record of Resident #C indicated the resident's diagnoses included, but were not limited to, senile dementia, constipation, urinary retention and hiatal hernia. The quarterly Minimum Data Set (MDS) for Resident #C, dated 8/18/14, indicated the following: the resident had severe cognitive impairment, bed mobility- extensive assistance of two people, walk in room- total dependence of one person, toilet use- extensive assistance of one person, urinary continence- resident had catheter, bowel continence- always incontinent and the resident was at risk for developing a pressure ulcer. The pressure ulcer assessment for Resident #C, dated 7/29/14 (no time), indicated the resident developed a stage two pressure at the facility and it was			

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	closed on 8/27/14. The monthly nursing assessment, dated 8/29/14 (no time), indicated the resident had potential for skin breakdown because of her history of previous breakdown and open areas. This Federal tag relates to Complaint IN00155060. 3.1-37(a)			
F000318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on interview and record review the facility failed to provide a functional Range Of Motion (ROM) program as recommended by therapy for a resident with limited range of motion for 1 of 3 residents reviewed for ROM in a total sample of 11 (Resident #A). Finding include: Review of the record of Resident #A on 9/15/14 at 9:55 a.m., indicated the	F000318	**F 318 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #A is confidential as part of the complaint survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee will identify and implement all residents recommended by therapy for a restorative program **Measures**	10/16/2014

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	resident's diagnoses included, but were not limited to, hypertension, diabetes mellitus, expressive aphasia (difficulty with speech), Cerbrovascular Accident (CVA) (stroke) and hemiplegia (paralysis) of the dominant side. The range of motion assessment for Resident #A, dated 8/2/14, indicated the resident had severe limitations of his neck, arms, hands, legs and foot and was not able to initiate the task of moving his joints and/or extremities. The resident had no voluntary movement. The admission Minimum Data Set (MDS) assessment for Resident #A, dated 8/7/14, indicated the following: cognitive skills for daily decision making was severely impaired, bed mobility-extensive assistance of two people, transfer- activity only occurred once or twice, walk in room- activity did not occur, functional limitation in Range of Motion- impairment on both sides of the upper and lower extremities. The physical therapy discharge summary for Resident #A, dated 8/7/14, indicated the resident indicated the resident was dependent for Passive Range Of Motion (PROM) of both lower extremities. The staff were to be independent in carrying out a Restorative Nursing Program		**put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the nursing staff on the following guideline: Contracture Prevention and Management Program Clinical Support Nurse will educate the Nursing Leadership team on the following: Range of Motion Assessment, Restorative Nursing Baseline Assessment, Restorative Program Care Plan, Restorative Program Tracking Form, Restorative Progress Note, Restorative Documentation in Care Tracker **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per hallway with restorative program recommendations from therapy will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Restorative program as recommended by therapy is implemented The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	(RNP). The staff were instructed on range of motion exercises and positioning in bed to prevent contractures and pressure ulcers. The occupational therapy discharge summary for Resident #A, dated 8/7/14, indicated the resident was dependent 100% for Activities of Daily Living (ADL) and mobility. The nursing staff educated on PROM and positioning. The resident was to be on RNP for functional maintenance. The restorative care program for Resident #A, dated 8/8/14, indicated the resident's goals for restorative program was to maintain current level of function with ROM and to decrease the risk of a decline. The approach/recommendations for implementation of the goals were complete ten reps three times of the upper and lower extremities with PROM. Interview with the Campus Clinical Support nurse on 9/15/14 at 3:15 p.m., indicated Resident #A was not started on a restorative nursing program for PROM. Campus Clinical Support nurse indicated it was the responsibility of the Director Of Health Services (DHS) to put the recommended restorative programs from therapy in place.			

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	Interview with the Physical Therapist on 9/16/14 at 11:25 a.m., indicated he made the recommendations for Resident #A to be on a restorative nursing program for PROM exercises. The Physical Therapist indicated he gives his recommendations to the DHS. The "Contractures Prevention and Management Program" policy provided by the Campus Clinical Support nurse on 9/15/14 at 2:50 p.m., indicated the purpose of the program was to prevent or reduce contractures and deformity, and/or preserve range of motion of residual limb to allow for use of prosthesis if needed through the provision of range of motion, stimulation of circulation, and muscle strengthening exercises. This Federal tag relates to Complaint IN00155060. 3.1-42(a)(2)			
F000425 SS=D	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			

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	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 continuity of care was provided between the local hospital and facility to ensure a resident received pain medication as needed and antibiotics as prescribed and failed to obtain medications from the facilities Emergency Drug Kit (EDK) or the back up pharmacy for 1 of 1 residents sampled for pharmacy services in a total sample of 11 (Resident #B). Findings include: Interview with Resident #B on 9/11/14 at 3:48 p.m., indicated he had been in the hospital for cellulitis (infection of the skin) of his legs and had returned to the facility on 9/9/14. Resident #B indicated when he returned from the hospital the facility nurse informed him that his pain medication and antibiotic was not	F000425	**F 425** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #B is confidential as part of the complaint survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: All new admissions for the past 5 days will be reviewed to ensure medications are available. **Measures put in place and**	10/16/2014

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	available at the facility. Resident #B indicated he was in a lot of pain with his legs the night of 9/9/14 and went all night without pain medication. Resident #B indicated on 9/10/14 he found out his pain medication was in a lock box at the nursing station. Resident #B indicated this was upsetting for him to find out his pain medicine had been available at the facility and he did not receive it during the night. Resident #B's family member indicated the resident had also missed his antibiotic and felt it was important that the resident received it as the physician had ordered. Resident #B indicated his legs were red and swollen and painful and he felt he should not have missed his antibiotic. Review of the record of Resident #B on 9/12/14 at 2:20 p.m., indicated the resident's diagnoses included, but were not limited to, malignant stage IV lung cancer, coronary artery disease, diabetes and cellulitis. The admission Minimum Date Set (MDS) assessment, dated 6/25/14, indicated the following: the resident's BIMS (Brief Interview for Mental Status) was a 13, with a range of 13-15, indicating the resident is cognitively intact, the resident experienced moderate pain and the pain made it hard for him to		**systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: Medication Ordering and Receiving From Pharmacy **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents / new admits will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Ensure continuity of care was provided between the admitting source and facility to ensure the resident received medications as ordered / as needed. In addition, the facility utilized the EDK or the back up pharmacy for medications ordered but not yet delivered. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	sleep and limited his day to day activities. The local hospital note for Resident #B, dated 8/30/14, indicated the resident had developed increased pain in the lower extremities and developed significant redness at the facility. The resident had significant pain in his lower extremities as well as warmth and redness. "It was determined that he had cellulitis. In light of the significant pain, discomfort, and due to his cellulitis as well as the fact that he was on chemotherapy, it was decided that it would be most appropriate to admit him for IV antibiotics." The discharge medication orders and instructions from the local hospital for Resident #B, dated 9/9/14, indicated the resident was orders included, but were not limited to, zyvox (antibiotic) 600 milligrams (mg) one tablet orally every eight hours with the next scheduled dose due on 9/9/14 at 8:00 p.m., amoxicillin-potassium clavulanate (antibiotic) 500 mg-125 mg one tablet orally every eight hours with the next scheduled dose on 9/9/14 at 10:00 p.m. and dilaudid (pain medication) 2 mg (1-2 tablets) orally every four hours as needed for pain, the last dose given was on 9/9/14 at 5:50 p.m. Review of the Medication Administration			

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	Record (MAR) for Resident #B, dated September 2014, indicated the resident did not receive zyvox 600 mg on 9/9/14 at 8:00 p.m., the first dose of zyvox the resident received was on 9/10/14 at 8:00 p.m. this indicated the resident missed two scheduled doses of zyvox. The MAR indicated the resident did not receive amoxicillin-potassium clavulanate on 9/9/14 at 10:00 p.m., the first dose of amoxicillin-potassium clavulanate the resident received was on 9/10/14 at 8:00 a.m. The MAR indicated the resident received dilaudid on 9/10/14 (no time). Interview with the Director of Health Services (DHS) on 9/15/14 at 1:00 p.m., indicated on 9/10/14 the day shift nurse obtained the dilaudid out of the facilities locked Emergency Drug Kit (EDK) and gave it to the Resident #B. The DHS indicated the protocol for obtaining medication for residents when they return from the hospital were some medications were available in the EDK and if they were not available the facility had a back up pharmacy. The DHS indicated the nurse can call the back up pharmacy and obtain the medication within two hours. The DHS indicated the evening shift nurse that worked the night of 9/9/14 was not aware dilaudid was available in the facilities EDK. The DHS indicated Resident #B informed her that on the			

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	night of 9/9/14 he was uncomfortable during the night and that his pain medication was not available. Interview with the DHS on 9/15/14 at 4:20 p.m., indicated she did not know what time Resident #B received his pain medication on 9/10/14 as the nurse did not document the time. The DHS indicated there was no time documented when the day shift nurse obtained the medicine from the EDK. During observation of the facilities EDK and interview with the DHS on 9/15/14 at 4:20 p.m., indicated zyvox was not available in the EDK, dilaudid 2 mg and amoxicillin-potassium clavulanate 500 mg-125 mg was available in the EDK. The DHS indicated on 9/9/14 the evening shift nurse faxed Resident #B's medication orders to the back up pharmacy instead of calling the medication orders in and having them brought to the facility that night. The medication ordering and receiving from pharmacy policy provided by Campus Clinical Support on 9/15/14 at 3:00 p.m., indicated "Emergency pharmacy service is available on a 24 hours basis." "Emergency needs for medication are met by using the facility's approved emergency medication supply			

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	or by special order from the provider pharmacy." "An emergency supply of medications, including emergency drugs, antibiotics and controlled substances will be provided to the facility." "Emergency drugs, antibiotics, infusion products and controlled substances are stored in designated secured area separate from patient medications." "Ascertains whether the ordered medication is contained in the emergency kit by referring to the list of contents posted on the box." "If the medication is not available, the nurse calls/fax the pharmacy, using the after-hours emergency number if necessary." 16.2-3.1-25(a)			
F000514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F000514		10/16/2014

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	Based on interview and record review the facility failed to document the time pain medications were given as to ensure the resident did not receive the medication before it was due as prescribed by the physician, failed to document where the resident's pain was located, failed to document the reason the pain medicine was given, failed to document the resident's pain on a scale from 1 to 10, failed to document interventions attempted before the pain medicine was given and failed to document the effectiveness of the pain medication given for 1 of 1 resident's reviewed for pain medication in a total sample of 11 (Resident #B). Finding include: Review of the record of Resident #B on 9/12/14 at 2:20 p.m., indicated the resident's diagnoses included, but were not limited to, malignant stage IV lung cancer, coronary artery disease, diabetes and cellulitis. The Physician recapitulation for Resident #B, dated 9/9/14 to 9/30/14, indicated the resident was ordered dilaudid 2 milligrams (mg) by mouth two tablets every four hours as needed for severe pain.		**F 514** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** Resident #B is confidential as part of the complaint survey. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken**: DHS or designee reviewed all residents with ordered PRN pain medications to ensure the following is being documented: time pain meds were given to ensure the resident did not receive the medication before it was due as prescribed by the MD, location of pain, reason for pain med administration, pain on a scale from 1-10, interventions attempted before the pain med was given, the effectiveness of the pain med. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** DHS or designee will re-educate the	

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	Interview with the Unit Manger on 9/12/14 at 3:30 p.m., indicated the nurses were responsible to fill out a PRN (as needed) medication log when they gave Resident #A his pain medication. The Unit Manager provided the PRN log and it was blank except Resident #A's name. The Medication Administration Record (MAR) for Resident #A indicated the resident received dilaudid 2 mg two tablets 3 times on 9/10/14, 3 times on 9/11/13 and one time on 9/12/14. There was no documentation of what time Resident #A received dilaudid 2 mg three times on 9/10/14. There was no documentation on the PRN medication tracking log for 9/10/14, 9/11/14 or 9/12/14 indicating the reason the pain medication was given, interventions attempted before the pain medication, the resident's pain prior to administration of the pain medicine on a scale from 1 to 10, the reason the pain medicine was given, the effectiveness of the pain medicine or what the resident's pain scale was after the pain medicine was given. Interview with the Director of Health Services (DHS) on 9/15/14 at 4:20 p.m., indicated she did not know what time Resident #B received his pain medication on 9/10/14 as the nurse did not document the time. The DHS indicated there was no		Licensed Nurses on the following guideline: 1. Pain Assessment and Management 2. PRN Medication Tracking Log **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:** The following audits and /or observations for 5 residents per hallway will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Residents with ordered PRN pain medications to ensure the following is being documented: time pain meds were given to ensure the resident did not receive the medication before it was due as prescribed by the MD, location of pain, reason for pain med administration, pain on a scale from 1-10, interventions attempted before the pain med was given, the effectiveness of the pain med. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	time documented when the day shift nurse obtained the medicine from the Emergency Drug Kit (EDK). The guidelines for pain assessment and management policy provided by the Campus Clinical Support nurse on 9/16/14 at 1:30 p.m. indicated the purpose was to ensure each resident's pain including the origin, location, severity, alleviating and exacerbating factors, current treatment and response to treatment will be assessed/reassessed and documented according to the needs of each individual. 3.1-50(a)(1)			