

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155526	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/02/2012
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NAME OF PROVIDER OR SUPPLIER PERSIMMON RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 N PARK ST PORTLAND, IN 47371
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F0000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: October 29, 30, 31, November 1, 2, 2012</p> <p>Facility number: 000148 Provider number: 155526 Aim number: 100275500</p> <p>Survey team: Betty Retherford, RN, TC Karen Lewis, RN Ginger McNamee, RN Suzanne Williams, RN [October 29, 30, 31, November 1, 2012]</p> <p>Census bed type: SNF/NF: 77 Total: 77</p> <p>Census payor type: Medicare: 11 Medicaid: 50 Other: 16 Total: 77</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 11/5/12</p>	F0000	<p>Submission of this Plan of Correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an or an agreement by the provider of the truth of the facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal Law. Please accept this Plan of Correction as our credible allegation of compliance.</p>	

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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	Cathy Emswiller RN				

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F0241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on record review and interview, the facility failed to ensure care was provided to each resident with dignity, regarding call lights not answered in a timely manner, and staff turning off the call light and leaving the resident's room without helping the resident, for 2 of 5 residents and 1 of 1 resident's family interviewed on the 500 hall, regarding dignity and staffing, of 18 residents who reside on the 500 hall (Residents #16, 80 and 85).</p> <p>Findings include:</p> <p>1. During interview on 10/30/12 at 10:20 a.m., Resident #80 indicated he has had to wait 1 1/2 hours for his call light to be answered. The resident indicated it was the worst on day shift, between 8 a.m. and 9 a.m., and this has happened repeatedly. The resident indicated staff will come in, turn the call light off, say they will be back, and they do not come back. "I'll ask for help at 9 a.m., then see her (the staff person) out on the hall</p>	F0241	<p>F241</p> <p>I. Residents 80, 85 and 16 (along with her family) were interviewed immediately with concerns of call lights not being answered timely and call lights being turned off without care being given. Reassurance given on the resolution of this concern. Monitoring implemented (See Attachment A). Resident #16 continues on hourly checks, #80 and 85 placed on hourly checks.</p> <p>II. In an effort to identify any other resident with a concern in regards to call lights being answered timely, the facility has initiated daily interviews with residents of the facility identified as "interviewable". Three resident interviews occurring per shift per unit. Administrative staff of the facility is ensuring that any concerns voiced by a resident and/or family member are appropriately investigated with corrective actions initiated immediately. (See Attachment A)</p> <p>III. As a means to ensure ongoing compliance, nursing staff have received in-service training in regard to timely response of call</p>	11/12/2012

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	<p>at noon; she never came back."</p> <p>Record review on 10/31/12 at 9:00 a.m. for Resident #80 indicated the resident was admitted on 3/27/12 with diagnoses including, but not limited to, hemiparesis, coronary artery disease, chronic obstructive pulmonary disease, dysphagia, recent CVA (cerebrovascular accident - stroke), and depression.</p> <p>The resident's quarterly Minimum Data Set (MDS) assessment, dated 8/16/12, indicated a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The assessment indicated the resident needed extensive assistance for bed mobility and transfers, dressing, and toilet use, and limited assistance for personal hygiene, and had frequent urine and bowel incontinence.</p> <p>2. During interview on 10/29/12 at 11:00 a.m., Resident #85 indicated, "it's a nightly occurrence" of having to wait for help. The resident indicated she turns her light on, and the staff turn off the call light, say "I'll be right back," or "I'll be a minute," and then they don't come back. Then, she has to turn her light on again for help. The resident indicated a lot of the</p>		<p>lights (Attachment D). The daily interviews of 3 residents per shift per unit will continue x 4 weeks. Interviews will continue at least twice weekly thereafter. Additionally, administrative nursing staff shall conduct routine call light monitoring during scheduled days of work to ensure timely call light response. (See Attachment A). Should non-compliance with the timely call light being answered be identified, immediate corrective action will be taken, including re-education and disciplinary action if warranted.</p> <p>IV. As a means of quality assurance, the administrator will review record of interviews conducted daily on scheduled work days times 4 weeks, and then twice weekly thereafter. The results of these interviews, and Administrative nursing call light monitoring will be provided to the quality assurance committee on a quarterly basis for review.</p> <p>Date of Completion: 11-12-12</p>		

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	<p>time, there has been a shift change and then the new shift says they didn't know she had been waiting for help. The resident indicated she has become incontinent because of having to wait for the bedpan. The resident also indicated she has had to wait long periods of time to get off of the bedpan.</p> <p>The resident indicated she has to wait long periods of time for help on all shifts.</p> <p>Resident #85's record was reviewed on 10/31/12 at 9:35 a.m. Diagnoses included, but were not limited to, nondisplaced oblique fracture of base of greater trochanter right hip, diabetes mellitus, hypertension, osteopenia, coronary artery disease, anxiety, and status post left-sided CVA (stroke).</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment, dated 9/12/12, indicated a BIMS (Brief Interview for Mental Status) score of 15, indicating no cognitive impairment. The assessment indicated the resident needed extensive assistance with bed mobility, transfers, locomotion on unit and off unit, dressing, toilet use, and bathing, and had occasional urinary incontinence.</p>						

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	<p>3. Interview with two family members of Resident #16 on 10/29/12 at 11:45 a.m. indicated it takes 30 to 35 minutes for staff to answer the call light at times on the day and evening shifts. The family members indicated they visit the resident daily. The family indicated staff will come in and turn the call light off, and then not come back. They then turn the call light on again and wait again.</p> <p>Resident #16's record was reviewed on 10/31/12 at 1:55 p.m. The record indicated the resident was receiving hospice services.</p> <p>The 8/14/12 significant change MDS assessment indicated the resident was cognitively impaired with altered level of consciousness and was totally dependent on staff for activities of daily living.</p> <p>4. Review of Resident Council minutes for meetings since January 2012, on 10/30/12 1:45 p.m., indicated the following resident complaints regarding call light response from staff: 4/10/12 meeting - Residents said staff turn off call light and leave without helping them. Resident Council Feedback from</p>						

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	<p>nursing, dated 4/17/12, indicated residents state aides turn off their call lights and tell residents they will be back to help and don't return, and call lights on third shift going off and aides do not acknowledge, at nurses' station talking.</p> <p>Nursing response indicated residents unable to give particular names, and all staff were inserviced on 4/16/12. 6/12/12 meeting - Residents complained regarding aides turning off call lights and leaving room before helping residents. 7/10/12 meeting - Documentation indicated the above was "resolved."</p> <p>During interview on 11/01/12 at 9:30 a.m., the Director of Nursing (DON) and RN Consultant were made aware of the above concerns from resident and family interviews regarding call light response times, and staff turning the light off, saying they will be back, then not returning to help the resident. The DON and RN Consultant indicated they would address the issue.</p> <p>Review of the "Call Light Procedure," dated 9/05, and provided as current policy by the RN Consultant on 11/01/12 at 11:25 a.m., indicated, "Purpose: To allow resident to request assistance when needed.</p>			

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	<p>Procedure: 1. Place call light within reach of resident at all times. 2. Answer light promptly. All staff should respond to a call light promptly (Bathroom/shower room call light immediately) 3. Announce to resident upon entering the room (knock on door if door is closed prior to opening). Be courteous when entering room. Ask resident: 'May I help you?' 4. Turn off call light. 5. Listen to the resident's request. Do not make him/her feel that you are too busy to help. 6. Respond to the request. If item is not available, or request questionable, get assistance from charge nurse. Return to resident with prompt reply. 6. Offer further services before leaving resident's room. 'Can I do anything else for you?'"</p> <p>3.1-3(t)</p>			

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F0332 SS=E	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure it was free of medication error rates of five percent or greater for 4 of 11 residents (Resident #'s 16, 86, 61 and 42) observed receiving medications from 3 of 9 nurses (LPN #'s 1 and 3 and RN #2) observed. This resulted in 6 medication errors from 54 opportunities for error and a medication error rate of 11%.</p> <p>Findings include:</p> <p>1.) During a med pass observation on 10/30/12 at 8:08 a.m., RN #2 was observed passing medications to Resident #16. RN #2 indicated the Resident's medications had to be crushed and put into applesauce when given. RN#2 set up multiple medications which included: Aspirin EC (enteric coated) 325 mg (milligrams) tab 1 and Mucinex (a medication given to thin secretions) ER (extended release) 600 mg tab 1.</p> <p>RN #2 prepared these medications to be crushed in the "pill crusher" device used by the facility. Prior to crushing</p>	F0332	<p>F332</p> <p>I Regarding Residents 16, 86, 61 and 42: The applicable attending physician has been notified and orders clarified, as warranted, in regard to medications contraindicated for crushing and medication times/with meals.</p> <p>II As all residents have the potential to be affected, the current recapitulation of physician's orders of all residents has been reviewed and any similar concerns identified. The applicable attending physician has been notified and orders clarified, as warranted, in regard to medications contraindicated from crushing, and medication times/with meals. Should any other concerns be noted, the same shall be addressed.</p> <p>III As a means to ensure ongoing compliance with ensuring irregularities in the medication regimen of each resident are reported and acted upon the DON or designee will monitor on scheduled work days all new orders to ensure that residents with "May Crush Medications" order do not receive medications contraindicated to crush, as well as daily checks of the MARS on scheduled work days to ensure</p>	11/12/2012	

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	<p>the meds, an inquiry was made related to whether medications that were an extended release type medication could be crushed. RN #2 checked the front of the medication administration record (MAR) and indicated these medications were not on the list of "Do Not Crush" medications. RN #2 indicated Resident #16 had an order allowing her medications to be crushed. She continued to crush the medications and administered the medications to Resident #16 in applesauce.</p> <p>The clinical record for Resident #16, reviewed on 10/31/12 at 10:00 a.m., contained current orders for the above medications but lacked any order indicating these medications could be crushed.</p> <p>The 2010 Nursing Drug Handbook indicated any extended release medication and should not be crushed when given. This would allow the entire dose of medication to be given at once instead of over an extended period of time. The handbook indicated enteric coated aspirin should not be crushed. This would allow the medication to be released in the stomach where it could cause gastric irritation instead of released in the intestines where the</p>		<p>times for medications/with meals are correct. Nursing staff was re-educated on proper procedures for Medication Administration policies (See Attachment D), including medications contraindicated for crushing and correct medication times/with meals. Up-Dated Do Not Crush list have been placed in the front of all MARS. Do Not Crush stickers have been ordered from pharmacy. Orders for "May Crush Medications" for appropriate residents have been obtained.</p> <p>IV As a means of quality assurance, the assigned the DON or designee will monitor all new orders on scheduled work days to ensure that residents with "May Crush Medications" order do not receive medications contraindicated to crush, as well as daily checks on scheduled work days of the MARS to ensure times for medications/with meals are correct (See Attachment B). Nurse Consultant shall review/audit the physician's orders of at least five residents monthly to monitor for irregularities in medication times and crushing of medications which are contraindicated (See Attachment C). Should irregularities be observed, the results of the monthly reviews/audits and any corrective action taken shall be reported to the Quality Assurance Committee during quarterly meetings.</p>		

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	<p>coating would be dissolved.</p> <p>During an interview with the RN Consultant on 10/31/12 at 10:10 a.m., additional information was requested related to the aspiring and Mucinex medications having been crushed prior to administration to Resident #16.</p> <p>During an interview on 10/31/12 at 10:15 a.m., the RN consultant indicated these items were not listed in front of the MAR as a "Do Not Crush" medication, but they should not be crushed due to their enteric coated or extended release status and the problem would be corrected.</p> <p>2.) During a med pass observation on 10/30/12 at 3:40 p.m., LPN #1 administered medications to Resident #61 which included Calcium 600 mg with Vitamin D 400 units (a supplement) tab 1. No food was given with the medication.</p> <p>The clinical record reviewed on 10/31/12 at 10:55 a.m., included the following current medication order for Resident #61: Calcium 600 mg with Vitamin D 400 units tab 1 twice daily with a meal. The times listed on the recapitulation of orders entered by the pharmacy staff for the medication to</p>		V 11-12-12				

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	<p>be given were 8 a.m. and 4 p.m.</p> <p>The schedule of meal times, provided by the Administrator on 10/29/12 at 10:30 a.m., indicated Resident #61's meal tray was not scheduled to arrive to her hall until 5:00 p.m. This indicated that the resident was administered the medication which was ordered to be given with meals one hour and 20 minutes before the meal cart would arrive on her hallway.</p> <p>3.) During a med pass observation on 10/30/12 at 3:48 p.m., LPN #1 administered medications to Resident #86 which included Potassium Chloride (a potassium supplement) ER 20 meq (milliequivalents) tab 1 and Potassium Chloride 8 meq tab 1. No food was given with the medication.</p> <p>The clinical record reviewed on 10/31/12 at 10:45 a.m., included the following current medication orders for Resident #86: Potassium Chloride ER 20 meq tab 1 twice daily with meals and Potassium Chloride ER 8 meq tab 1 twice daily with meals. The times listed on the recapitulation of orders entered by the pharmacy staff for the medication to be given were 8 a.m. and 4 p.m.</p>				

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	<p>The schedule of meal times, provided by the Administrator on 10/29/12 at 10:30 a.m., indicated Resident #86's meal tray was not scheduled to arrive to her hall until 5:00 p.m. This indicated that the resident was administered the medication to be given with a meal one hour and 12 minutes before the meal cart would arrive on her hallway.</p> <p>4.) During a med pass observation on 10/30/12 at 4:13 p.m., LPN #3 administered medications to Resident #42 which included ferrous sulfate 325 mg tab 1. No food was given with the medication.</p> <p>The clinical record for Resident #42 reviewed on 10/31/12 at 10:40 a.m., included the following current medication order for Resident #42: ferrous sulfate (an iron supplement) 325 mg tab 1 twice daily with meals. The times listed on the recapitulation of orders entered by the pharmacy staff for the medication to be given were 8 a.m. and 4 p.m.</p> <p>The schedule of meal times, provided by the Administrator on 10/29/12 at 10:30 a.m., indicated Resident #42's meal tray was not scheduled to arrive to her hall until 5:20 p.m. This indicated that the resident was</p>						

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	<p>administered the medication to be given with a meal one hour and 7 minutes before the meal cart would arrive on her hallway.</p> <p>5.) During an interview on 11/2/12 at 9:45 a.m., the DoN indicated when an order is received by the physician that does not include the specific times a med is to be given, the standard medication times are entered by the pharmacy staff. She indicated 4 p.m. would not be a time to give a medication that was to be given with a meal and these concerns had already been addressed.</p> <p>6.) The 1/10, revised "Medication Administration Policy And Procedure" was provided by the RN Consultant on 11/1/12 at 10:50 a.m. The purpose was to administer medications according to the guidelines set forth by the State and Federal Regulations. The procedure indicated the altering of medications such as crushing or opening capsules must have documentation by the Medical Doctor of Pharmacist in chart stating "May crush medications." The procedure indicated medication would be given with food or antacids, if ordered.</p> <p>3.1-48(c)(1)</p>				

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F0428 SS=E	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure irregularities in the medication regimen of each resident were reported by the pharmacist and acted upon, for 7 of 10 residents reviewed for unnecessary medications (Residents #14, 42, 56, 61, 83, 85, 86).</p> <p>Findings include:</p> <p>1.) Review of Resident #85's record on 10/31/12 at 9:35 a.m. indicated the following diagnoses: nondisplaced oblique fracture of base of greater trochanter right hip, diabetes mellitus, hypertension, osteopenia, coronary artery disease, anxiety, and status post left sided CVA (cerebrovascular accident - stroke). The resident was admitted to the facility on 6/13/12.</p> <p>The record indicated the pharmacist reviewed Resident #85's medication regimen in June, July and August</p>	F0428	<p>F428</p> <p>I. Regarding Residents 14, 42, 56, 61, 83, 85 and 86: The applicable attending physician has been notified and orders clarified, as warranted, in regard to appropriate diagnosis/rationale for medication use, medication times/with meals, level of pain applicable to analgesics, PRN medication frequency and intervals of administration, and revising to routine use, if PRN use is inappropriate.</p> <p>II. As all residents have the potential to be affected, the current recapitulation of physician's orders of all residents has been reviewed and any similar concerns identified. The applicable attending physician will be notified and orders clarified, as warranted, in regard to appropriate diagnosis/rationale for medication use, medication times/with meals, level of pain applicable to analgesics, PRN medication frequency and intervals of administration, and revising to routine use, if PRN</p>	11/12/2012	

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	<p>2012.</p> <p>The October physician order recaps, signed by the physician on 10/17/12, included, but were not limited to, the following medication orders: Glucosamine 500 mg 3 caps (1500 mg) by mouth daily, ordered on 6/13/12, for diabetes mellitus Multilex (multivitamin with minerals) one tablet by mouth daily x 90 days, ordered on 6/18/12 Glucophage (Metformin) 500 mg by mouth twice a day with meals, with the times of 8 a.m. and 4 p.m. listed, for diabetes mellitus.</p> <p>Review of the physician order, dated 6/18/12, indicated to start a multivitamin with minerals daily for 90 days. The multivitamin should have been given through 9/16/12, according to this physician's order.</p> <p>Review of the Medication Administration Records for June through October 2012 indicated the following: The Multilex (multivitamin with minerals) was given daily, June 18 through October 31, 2012. The Glucophage (Metformin) was documented as given at 8 a.m. and 4 p.m. daily. The 4 p.m. dose was not given with a meal. Review of the</p>		<p>use is inappropriate. Should any other concerns be noted, the same shall be addressed.</p> <p>III. As a means to ensure ongoing compliance with ensuring irregularities in the medication regimen of each resident are reported and acted upon, the contracted pharmacy was contacted and education was provided to the facility consultant pharmacist to include, but not be limited to: a.) Monitoring for appropriate diagnosis/rationale for medication use; b.) Monitoring for medication orders which have stop-dates and/or are time-dated (e.g., for 90 days); c.) Monitoring for medications which are ordered to be administered with medications and ensuring the time assigned corresponds with facility meal times; d.) Monitoring to ensure PRN analgesic medications have listed within the order the type and/or level of pain for the use of the medication; e.) Monitoring to ensure that applicable medications (e.g., Nitrostat) have directions related to when the medication is to be given and at what intervals, with a maximum dosage; f.) Monitoring to ensure PRN medications list the frequency at which the PRN medication can be administered; g.) Monitoring to ensure that a medication listed as PRN is appropriate and/or effective if given PRN.</p> <p>IV. As a means of quality assurance, the assigned Nurse</p>		

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	<p>facility's schedule of meal times indicated the evening meal is scheduled for 6 p.m., on the West wing, where this resident resides.</p> <p>Review of the 2010 Nursing Spectrum Drug handbook indicated the following: Metformin (Glucophage) - Administer with a meal Glucosamine - Reported uses: osteoarthritis, joint pain and inflammation, TMJ (temperomandibular joint) syndrome, glaucoma, and to aid weight loss. Diabetes mellitus was not an indication for the use of Glucosamine.</p> <p>During interview on 10/31/12 at 3:00 p.m., the RN Consultant was informed of the irregularities in Resident #85's medication regimen, regarding the Glucosamine, Glucophage (Metformin) and the multivitamin.</p> <p>Interview with the Director of Nursing (DON), on 11/01/12 at 8:35 a.m., indicated the pharmacist reviewed Resident #85's chart on 8/27/12 and 9/30/12 with no recommendations. The DON confirmed the pharmacist did not report the irregularities, regarding the Glucosamine being given for diabetes, Glucophage</p>		<p>Consultant shall review/audit the physician's orders of at least five residents monthly following consultant pharmacist medication regimen review, ongoing (See Attachment C). Should irregularities be observed which were not identified by the consultant pharmacist, the contracted pharmacy shall be notified in an effort the corrective action plan be amended accordingly. The results of the monthly reviews/audits and any corrective action taken shall be reported to the Quality Assurance Committee during quarterly meetings.</p> <p>V. 11-12-12</p>	

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	<p>(Metformin) not given with a meal at 4 p.m. daily, or the multivitamin with minerals given for more than the ordered 90 days.</p> <p>Interview with Assistant Director of Nursing (ADON), on 11/01/12 at 8:45 a.m., indicated physician orders were received on 10/31/12 for Glucosamine for joint supplement, and the multivitamin was to be continued daily. The ADON confirmed the pharmacist did not report irregularities regarding the multivitamin, Glucosamine for diabetes mellitus, and Glucophage being given at 4 p.m. daily, rather than with meals.</p> <p>2.) The clinical record for Resident #61 was reviewed on 10/31/12 at 10:55 a.m.</p> <p>The November recapitulation of physician orders, signed on 10/31/12, included the following current medication order for Resident #61: Calcium 600 mg with Vitamin D 400 units tab 1 twice daily with a meal. The times listed on the recapitulation of orders entered by the pharmacy staff for the medication to be given were 8 a.m. and 4 p.m. The original date of this order was 4/28/10.</p>			

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	<p>The schedule of meal times, provided by the Administrator on 10/29/12 at 10:30 a.m., indicated Resident #61's meal tray was not scheduled to arrive to her hall until 5:00 p.m.</p> <p>The clinical record indicated the Consultant Pharmacist had reviewed the residents clinical record on 8/23/12 and lacked any information related to a recommendation to change the 4 p.m. medication administration time to a time that would have it given with meals.</p> <p>During an interview on 11/1/12 at 8:45 a.m., the DoN indicated the Consultant Pharmacist had reviewed the resident's record on 8/23/12 and 9/30/12. She indicated she had not received any recommendations related to a need to change the administration times for the calcium medication noted above.</p> <p>3.) The clinical record for Resident #86 was reviewed on 10/31/12 at 10:45 a.m.</p> <p>The November recapitulation of physician orders, signed on 10/31/12, included the following current medication orders for Resident #86: Potassium Chloride ER 20 meq tab 1</p>				

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	<p>twice daily with meals and Potassium Chloride ER 8 meq tab 1 twice daily with meals. The times listed on the recapitulation of orders entered by the pharmacy staff for the medications to be given were 8 a.m. and 4 p.m. The original date of these orders were 5/3/12.</p> <p>The schedule of meal times, provided by the Administrator on 10/29/12 at 10:30 a.m., indicated Resident #86's meal tray was not scheduled to arrive to her hall until 5:00 p.m.</p> <p>The clinical record indicated the Consultant Pharmacist had reviewed the residents clinical record on 8/23/12 and lacked any information related to a recommendation to change the 4 p.m. medication administration time to a time that would have it given with meals.</p> <p>During an interview on 11/1/12 at 8:45 a.m., the DoN indicated the Consultant Pharmacist had reviewed the resident's record on 8/23/12. She indicated she had not received any recommendations related to a need to change the administration times for the potassium medication noted above. She indicated she was unable to find any information related to the pharmacist reviewing the resident's</p>				

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	<p>clinical record during his visit on 9/30/12. She indicated the pharmacist had visited the facility in October, but she had not received any recommendations from that visit and did not know what resident records had been reviewed.</p> <p>4.) The clinical record for Resident #42 was reviewed on 10/31/12 at 10:40 a.m.</p> <p>The October recapitulation of physician orders, signed on 9/15/12, included the following current medication order for Resident #42: ferrous sulfate (an iron supplement) 325 mg tab 1 twice daily with meals. The times listed on the recapitulation of orders entered by the pharmacy staff for the medication to be given were 8 a.m. and 4 p.m. The original date of this order was 9/10/12.</p> <p>The schedule of meal times, provided by the Administrator on 10/29/12 at 10:30 a.m., indicated Resident #42's meal tray was not scheduled to arrive to her hall until 5:20 p.m.</p> <p>The clinical record for Resident #42 lacked any information related to a pharmacy review and/or pharmacy recommendations for the resident r/t the medication administration time</p>				

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	<p>having not been with a meal for the ferrous sulfate medication.</p> <p>During an interview on 11/1/12 at 8:45 a.m., the DoN indicated the Consultant Pharmacist had been in the facility on 9/30/12 and had also completed October reviews. She indicated she had not received any recommendations for Resident #42 related to the administration time of the ferrous sulfate medication not being given with a meal.</p> <p>5.) Resident #56's clinical record was reviewed on 10/30/12 at 1:42 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, depression, osteoporosis, and history of rib and left femur fracture.</p> <p>The resident's current Physician's Orders were signed and dated by the physician on 10/10/12. The resident had an ongoing order originating on 4/13/10, for acetaminophen 325 mg tablet take two tablets by mouth every four hours as needed for pain or elevated temperature. The resident had an ongoing order originating on 4/15/12, for hydrocodone-apap 5-325 mg tablet take one tablet by mouth four times a day as needed for pain. The orders lacked parameters related to the type and/or level of pain for the</p>				

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	<p>use of the pain medications.</p> <p>Review of the resident's clinical record indicated the resident's Physician's Orders had been reviewed by the Consultant Pharmacist on 8/23/12, with no recommendations related to clarifying the pain medications.</p> <p>During an interview with the Director of Nursing on 11/1/12 at 8:25 a.m., she indicated the Consultant Pharmacist had reviewed the resident's record on 9/30/12 and on 10/26/12 or 10/29/12. She indicated she had not received any recommendations related to the resident's pain medications.</p> <p>6.) Resident #14's clinical record was reviewed on 10/30/12 at 2:44 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure, hypertension, dementia, and intractable constipation.</p> <p>The resident's current Physician's Orders were signed and dated by the physician on 10/10/12. The resident had an ongoing order for Nitrostat [a heart medication]0.4 mg tablet sublingual take one tablet under tongue as needed. This order originated on 7/11/11. The order</p>				

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	<p>lacked directions related to when the medication was to be given and at what intervals with a maximum dosage.</p> <p>Review of the facility's copy of the "2009 Drug Information Handbook for Nursing" indicated "Nitrostat....Sublingual: 0.2-0.6 mg every 5 minutes for maximum of 3 doses in 15 minutes; may also use prophylactically 5-10 minutes prior to activities which may provoke an attack...."</p> <p>The resident had an order for bisacodyl [laxative] 10 mg suppository insert 1 suppository rectally as needed for constipation. This order originated on 3/10/08, and has been ongoing. The order lacked the frequency the suppository was to be given.</p> <p>Review of the resident's clinical record indicated the resident's Physician's Orders had been reviewed by the Consultant Pharmacist on 8/23/12, with no recommendations related to clarifying the Nitrostat and bisacodyl suppository orders.</p> <p>During an interview with the Director of Nursing on 11/1/12 at 8:25 a.m.,</p>			

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	<p>she indicated the Consultant Pharmacist had reviewed the resident's record on 9/30/12 and on 10/26/12 or 10/29/12. She indicated she had not received any recommendations related to the resident's Nitrostat and bisacodyl suppository.</p> <p>7.) The clinical record for Resident #83 was reviewed on 11/1/12 at 8:46 a.m.</p> <p>Diagnoses for Resident #83 included, but were not limited to, depression, atrial fibrillation, and Alzheimer's dementia with delusions.</p> <p>Current physician's orders for Resident #83 included, but were not limited to, the following orders:</p> <p>a. Nitrostat (a medication given for angina discomfort) 0.4 milligrams (mg) 1 tablet sublingually as needed for chest pain (original order date 3/29/12).</p> <p>The clinical record lacked any information or directions from the physician related to how often this "as needed" medication could be given. The "2009 Drug Information Handbook for Nursing" indicates Nitrostat is to be given every 5</p>						

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	<p>minutes for a maximum of 3 doses in 15 minutes.</p> <p>b. Nicotine (a medication to reduce the desire to smoke) 14 mg/24 hour patch. Apply 1 patch topically every day as needed (original order date 3/29/12).</p> <p>The clinical record lacked any information from the physician related to why this medication would be used as an "as needed" medication. The "2009 Drug Information Handbook for Nursing" does not indicate the nicotine patch can be used as an "as needed" medication.</p> <p>The clinical record indicated the pharmacist reviewed the physician's orders on 8/23/12 and 9/30/12, and no recommendations were made to clarify the above noted incomplete physician's orders.</p> <p>During an interview with the Director of Nursing and the RN Consultant on 11/1/12 at 2:14 p.m., additional information was requested related to the lack of clarifications obtained for the "as needed" medications noted above following pharmacy reviews on 8/23/12 and 9/30/12.</p> <p>The facility failed to provide any</p>						

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	<p>additional information as of exit on 11/3/12.</p> <p>8.) During an interview on 11/2/12 at 9:45 a.m., the DoN indicated when an order is received by the physician that does not include the specific times a med is to be given, the standard medication times are entered by the pharmacy staff. She indicated 4 p.m. would not be a time to give a medication that was to be given with a meal and these concerns had already been addressed.</p> <p>9.) Review of the "Drug Regimen Review" policy and procedure, provided as current policy by the RN Consultant on 11/01/12 at 1:46 p.m., indicated the following under "Policy": "The consultant pharmacist will review the drug regimen of all skilled and intermediate care residents at least monthly and report any observed irregularities in drug use and other drug therapy recommendations to the director of nursing, attending physician, administrator, and if applicable, the medical director. Drug regimen reviews (DRR) will include all medications currently ordered for each resident, regardless of pharmacy supplier." "Procedures" indicated, "...2. The</p>				

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	<p>consultant pharmacist will review the medication orders, progress notes, laboratory reports, and MARs (Medication Administration Records) for each resident to evaluate the safety and efficacy of drug therapy, to detect the existence of actual or potentially harmful conditions, and the accuracy of medication administration...The consultant pharmacist will also assess the accuracy of transcribed orders, check for duplication of medications, look for documentation of medical reason for drug use and for appropriate physical, behavioral and laboratory monitoring of therapy...."</p> <p>3.1-25(i)</p>			