

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/30/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00177273.</p> <p>Complaint IN00177273 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F425.</p> <p>Survey dates: July 29 & 30, 2015</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census Payor type: Medicare: 9 Medicaid: 65 Other: 8 Total: 82</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 0282	483.20(k)(3)(ii)			

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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SS=D Bldg. 00	<p>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to follow Physician's Orders and care plans related to lack of administration of scheduled pain medication as ordered for 2 of 4 residents reviewed for scheduled pain medication in a sample of 4. (Resident #B and #D)</p> <p>Findings include:</p> <p>1. Resident #D's closed record was reviewed on 7/29/15 at 10:45 a.m. Diagnoses included, but were not limited to, fractured lumbar vertebrae, senile dementia, schizoaffective disorder and chronic airway obstruction.</p> <p>Review of the June and July 2015 POS (Physician Order Summary) indicated an order for Duragesic (narcotic pain medication) 25 patch 72 hour - apply 25 mcg (micrograms)/ hr (hour) transdermally (to the skin) in the morning every 3 days for pain and remove per schedule.</p> <p>Review of the June 2015 MAR (Medication Administration Records)</p>	F 0282	<p>1) Resident #D is no longer in the facility and Resident #B was examined to make certain that her care planned pain medication was in place. 2) Any resident with Physician orders for scheduled pain medications have the potential to be affected. Care plans were reviewed with physician orders to ensure that residents were receiving medication as care planned. No deficiencies were found. 3) A. Nurse's were in-serviced on following care plans related to physician orders to ensure administration is per the care plan. The facility has added to its systems that care plans for new orders will be reviewed in morning meeting to ensure care plans match current order. B. DNS or designee will use an audit tool to verify that care plans are being followed. Audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary.</p>	08/29/2015

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	<p>indicated an entry on 6/30/15 to "See Nurse Notes."</p> <p>Review of the July 2015 MAR indicated an entry on 7/3/15 to "See Nurse Notes."</p> <p>Review of a Progress Note titled eMAR - Medication Administration Note dated 6/30/15 indicated, "on order from pharmacy, pharmacy aware, awaiting new order."</p> <p>Review of a Progress Note titled eMAR - Medication Administration Note dated 7/3/15 indicated, "not available at this time. Pharmacy awaiting script for med. MD notified. Will apply when received."</p> <p>Review of a Progress Note dated 7/4/15 indicated Resident #D had rolled out of bed and had complained of back pain and was sent to the Emergency Room (ER) for evaluation and treatment.</p> <p>Interview with Resident #D's daughter/ POA (Power of Attorney) on 7/29/15 at 10:30 a.m. indicated she observed a Duragesic patch dated 6/27/15 on the resident's back while she was examined in the ER on 7/4/15.</p> <p>Interview with the South Unit Manager (UM) on 7/30/15 at 9:50 a.m. indicated there was no documentation to indicate</p>			

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	<p>Resident #D had received her prescribed Duragesic pain patch on 6/30/15 or 7/3/15.</p> <p>2. Resident #B's record was reviewed on 7/29/14 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, psychosis with delusions, hemiplegia, and peripheral vascular disease.</p> <p>Review of current Physicians Orders indicated an order for Fentanyl Patch 72 hour 25 mcg (micrograms)/ hr (hour) - apply 1 patch transdermally (on the skin) one time a day every 3 days for pain and remove per schedule.</p> <p>Review of the MARs (Medication Administration Records) from January through July 2015 indicated no charting of the Fentanyl patch being administered on 4/14/15, 6/28/15 and 7/10/15. There was also an entry on 6/16/15 to "See Nurse Note."</p> <p>Review of a Progress Note titled eMAR - Medication Administration Note dated 6/16/15 indicated, "Patch not available. Spoke with pharmacy technician and they are waiting on a new script. MD aware. Will apply when arrives from pharmacy." The Progress Notes lacked documentation to indicate the patch was</p>			

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F 0425 SS=D Bldg. 00	<p>applied.</p> <p>Interview with the South Unit Manager (UM) on 7/30/15 at 9:50 a.m., indicated there was no documentation to indicate Resident #B had received her prescribed Fentanyl pain patch on 4/4/15, 6/16/15, 6/28/15, or 7/10/15.</p> <p>This Federal tag relates to Complaint IN00177273.</p> <p>3.1-35(g)(2)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who</p>				

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	<p>provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on record review and interview, the facility failed to ensure medications were reordered and available for residents timely, related to scheduled pain patches not available to administer to residents as ordered by the residents' Physicians, for 2 of 4 residents reviewed for scheduled pain medication administration in a sample of 4. (Residents #B and #D)</p> <p>Findings include:</p> <p>1. Resident #D's closed record was reviewed on 7/29/15 at 10:45 a.m. Diagnoses included, but were not limited to, fractured lumbar vertebrae, senile dementia, schizoaffective disorder, and chronic airway obstruction.</p> <p>Review of the June and July 2015 POS (Physician Order Summary) indicated an order for Duragesic (narcotic pain medication) 25 patch 72 hour - apply 25 mcg (micrograms)/ hr (hour) transdermally (to the skin) in the morning every 3 days for pain and remove per schedule.</p> <p>Review of the June 2015 MAR (Medication Administration Records) indicated an entry on 6/30/15 to "See</p>			F 0425	<p>1) Resident #D is no longer in the facility. Resident #B's pain medication was on hand and available for administration. Current Duragesic patch was in place with correct administration date. 2) Any resident with Physician orders for scheduled pain medications have the potential to be affected. Dr. Orders and availability were reviewed to ensure that residents medications were available and being provided as ordered. No deficiencies were found. 3) A. Nurse's were in-serviced on procedure for re-ordering medications timely from the pharmacy. B. DNS or designee will use an audit tool to record that scheduled pain medications are re-ordered timely and are available and being administered as ordered. The audit tool will be completed by the DNS/designee 5 times per week for 4 weeks, then weekly for 8 weeks, and then monthly for 12 weeks. 4) Audit tool will be reviewed monthly for 6 months in facility QAPI meeting unless further monitoring is deemed necessary.</p> <p>The facility respectfully requests that paper compliance be given consideration for these tags.</p>		08/29/2015

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	<p>Nurse Notes."</p> <p>Review of the July 2015 MAR indicated an entry on 7/3/15 to "See Nurse Notes."</p> <p>Review of a Progress Note titled eMAR - Medication Administration Note dated 6/30/15 indicated, "on order from pharmacy, pharmacy aware, awaiting new order."</p> <p>Review of a Progress Note titled eMAR - Medication Administration Note dated 7/3/15 indicated, "not available at this time. Pharmacy awaiting script for med. MD notified. Will apply when received."</p> <p>Review of a Progress Note dated 7/4/15 indicated Resident #D had rolled out of bed and had complained of back pain and was sent to the Emergency Room (ER) for evaluation and treatment.</p> <p>Interview with Resident #D's daughter/ POA (Power of Attorney) on 7/29/15 at 10:30 a.m. indicated she observed a Duragesic patch dated 6/27/15 on the resident's back while the resident was being examined in the ER on 7/4/15.</p> <p>Interview with the South Unit Manager (UM) on 7/30/15 at 9:50 a.m. indicated there was no documentation to indicate Resident #D had received her prescribed</p>			

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	<p>Duragesic pain patch on 6/30/15 or 7/3/15.</p> <p>Interview with LPN #1 on 7/30/15 at 10:15 a.m. indicated Duragesic patches were usually delivered in boxes of five or ten patches and the label to reorder was faxed to the pharmacy when one patch remained. She further indicated the night shift nurse applied the patches and usually pulled off the reorder label, then passed along the information on the 24 hour report. The pharmacy would notify the facility if a new prescription was needed, then send a fax to the Physician requesting a new prescription. She further indicated if the facility was made aware of the need for a new prescription, it was easy for the day shift staff to contact the Physician or pharmacy during business hours to follow up. She also indicated she had worked with Resident #D during the timeframe her Duragesic pain patch was not available and was unaware of the need for a refill or a new prescription and unsure where the breakdown in communication occurred.</p> <p>2. Resident #B's record was reviewed on 7/29/14 at 10:00 a.m. Diagnoses included, but were not limited to, dementia, psychosis with delusions, hemiplegia, and peripheral vascular disease.</p>			

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	<p>and distribution and followed the Alixa Pharmacy policies.</p> <p>An Alixa policy titled Medication Orders Controlled Substance Prescriptions was provided by the South UM on 7/29/15 and deemed as current. The policy indicated, ".... F. Refill Requests ... 1) If one or more refills or a partial fill quantity remains and medications are not automatically refilled by the pharmacy, refills are: a. written on a medication order form or ordered by peeling the top label from the label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and requested from the pharmacy 5 days in advance of need to assure an adequate supply is on hand. 2) If only one refill or only a partial fill quantity remains, the pharmacy will simultaneously dispense the remaining refill, contact the facility to verify continuation of the medication is necessary, and, if necessary proactively seek out a new, complete prescription from the prescriber for future use. If a new prescription is not obtained by the pharmacy before the medication would be "due" again, the facility is notified. In this situation, the facility may e asked to contact the prescriber for a new prescription prior to the medication running out"</p>			

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

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