

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155765	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED  09/29/2011
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NAME OF PROVIDER OR SUPPLIER  SOUTHERN INDIANA REHAB HOSPITAL-PCU	STREET ADDRESS, CITY, STATE, ZIP CODE 3104 BLACKISTON BLVD NEW ALBANY, IN47150
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F0000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: September 27, 28, and 29, 2011</p> <p>Facility Number: 005649 Provider Number: 155765 AIM Number: N/A</p> <p>Survey Team: Gloria J. Reisert, MSW-TC Dorothy Navetta, RN</p> <p>Census Bed Type: SNF: 25 Total: 25</p> <p>Census Payor Type: Medicare: 22 Medicaid: 0 Other: 3 Total: 25</p> <p>Sample: 10 Supplemental Sample: 4</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September</p>	F0000		

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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F0282 SS=D	<p>30, 2011 by Bev Faulkner, R.N.</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, interview and observation, the facility failed to follow physicians orders to continue an antibiotic and perform feeding tube site care on 1 of 1 resident reviewed for antibiotic use and feeding tube care in sample of 10. (Resident # 24)</p> <p>Findings include:</p> <p>1.a. Review of the clinical record for Resident # 24 on 9/27/2011 at 12:50 p.m., included diagnoses of, but not limited to; gastrostomy tube feedings (feedings into stomach via a tube) related to dysphagia (difficulty swallowing), and Clostridium difficile (infection in stool).</p> <p>A physician order written on 9/16/2011 indicated "D/c [discontinue] Flagyl after last dose 9/21." Flagyl is an anti-infective used to treat Clostridium difficile infection.</p>	F0282	<p>1a. MD was contacted on 9/27/2011 to d/c the Flagyl for patient #24. Lab results were received on 9/21/2011 showing a negative c-diff toxin. The statement in paragraph 3 of the 2567 under "Findings include:..." A new physician order was written on 9/24/2011..." is incorrect. The new order was written on 9/20/2011 prior to receiving the negative lab results on 9/21/2011. 1b. Patient #24 was immediately assessed by the Associate Nurse Manager. Tube site was clean, dry, intact, with no redness, drainage or s/s of infection. Site was cleaned with soap and water as stated. Documentation shows that the tube site was assessed every shift since admission. 2a. Upon further review, it was noted the updated order written on 9/20/2011 was not stamped or written "faxed" to pharmacy. This is consistent with why the updated order was not reflected on the updated MAR on 9/22/2011. A 100% chart review was completed by October 7, 2011 ensuring all orders containing medications have been faxed to the pharmacy and the MAR was current.2b. No</p>	10/20/2011			

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	<p>A new physician order was written on 9/24/2011 which indicated "continue Flagyl-do not stop."</p> <p>Review of the Medication Administration Record (MAR), dated "09/20/2011, 23:00 (11:00 p.m.) thru 09/21/2011 22:59 (10:59 p.m.)" indicated that Resident # 24 received Flagyl 500 milligrams (m.g.) at 6:00 a.m., 2:00 p.m., and 10:00 p.m.</p> <p>Review of the MAR's from 9/24/2011 thru 9/27/2011 lacked documentation that the Flagyl was continued as per the physician order.</p> <p>On 9/27/2011 at 1:45 p.m., in an interview with the Associate Unit Manager # 1 she indicated that the order on 9/24/2011 to continue the Flagyl was "missed".</p> <p>b. Resident # 24 was admitted to facility with feeding tube in place and review of the physician admission orders for Resident # 24, dated 9/16/2011, indicated, "peg tube (tube into stomach for feeding) care every shift with soap and water".</p> <p>Review of nursing notes, dated from 9/16/2011 at 10:00 p.m. to 9/28/2011 1:30</p>		<p>other patients were receiving tube feedings or g-tube care. A chart review of all patients with skin treatment orders was completed by October 7, 2011 ensuring proper documentation. 3a. All physician orders containing medication changes are to be faxed to the pharmacy for the next day's MAR changes. A "FAXED" stamp will now be required including the date and time faxed. The unit secretary or nurse is responsible for ensuring this is completed. The nurse taking off the order is to verify this occurs. By October 20, 2011, all unit secretaries and nurses will receive additional education relating to this faxing and verification process. This process was added as an agenda item to the huddle meeting held at the change of each shift on October 6, 2011 to communicate the importance of the stated process. It will be on the huddle meeting agenda for 2 weeks. 3b. All physician treatment orders are entered into the EMR via the intervention section and should automatically show up in the treatment box for the nurse to chart against if completed. Upon further review, the specific treatment was not carried over to the treatment box leading to a lack of documentation that the treatment was being done. The intervention was listed on the printed "walking papers" used for nursing report, communication of</p>		

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	<p>p.m., indicated that the peg tube care was completed on 9/16/2011 at 10:00 p.m.; 9/17/2011 at 6:00 a.m.; 9/19/2011 at 2:00 p.m.; 9/20/2011 at 1:05 p.m.; 9/21/2011 at 2:00 p.m.; 9/22/2011 at 2:00 p.m.; 9/24/2011 at 2:00 p.m.; 9/25/2011 at 2:00 p.m.; 9/27/2011 at 2:00 p.m., and 9/28/2011 at 1:30 p.m.</p> <p>Documentation was lacking that care of peg tube was done every shift as ordered by physician.</p> <p>Upon request on 9/28/2011 at 2:00 p.m., the Associate Unit Manager # 1 (AUM) reviewed the on line nursing notes to see if she could find any further documentation on the cleansing of the peg tube as ordered. AUM # 1 reviewed the MAR and the Treatment Administration Record (TAR) to see if the care was documented in either of them. At 2:15 p.m., the AUM # 1 indicated that she could not find any documentation that the cleansing of the peg tube site was being done as ordered.</p> <p>Review of the facility's schedules indicated that nursing shifts were 8 hour shifts with 12 hour weekend shifts.</p> <p>On 9/29/2011 at 9:45 a.m., Resident # 24 was observed to have a feeding tube into</p>		<p>changes, and treatment orders. The software vendor has been made aware to investigate and correct. By October 20, 2011 all nurses will receive additional education related to treatment orders and to compare the interventions listed on the "walking papers" to the treatments built in the EMR. 4a. The Associate Nurse Manager or designee will perform a 100% chart audit weekly for eight weeks to ensure all orders containing medications have been faxed to the pharmacy. The audit results will be reported to the Quality Council to determine the need for continued written audits. A minimum of 100% compliance for six weeks will be expected. The unit secretary will continue spot checks to ensure orders containing medications have been faxed to the pharmacy and will report any noncompliance to the Associate Nurse Manager. 4b. The Associate Nurse Manager or designee will perform a 100% chart audit weekly for eight weeks to ensure proper documentation related to carrying out treatment orders. The audit results will be reported to the Quality Council to determine the need for continued written audits. A minimum of 100% compliance for six weeks will be expected. All charts will be reviewed by the Associate Nurse Manager within 72 hours of admission to ensure treatments</p>				

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F0332 SS=D	<p>the stomach and LPN # 1 performed the cleaning of the peg tube site. 3.1-35(g)(2)</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater. Based on observation, record review and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 13 residents observed receiving medications. 3 errors in medication were observed during 13 opportunities for error in medication administration. This resulted in a medication error rate of 7.5%. The deficient practice affected 3 Residents. (Resident # 14, Resident # 19, Resident # 21)</p> <p>Findings include:</p> <p>1. On 9/27/2011 at 11:45 a.m., during observation of the medication pass for Resident # 19, Licensed Practical Nurse (LPN) # 1 administered an insulin injection of Humalog 3 units in the left</p>	F0332	<p>are entered correctly into the EMR.</p> <p>1. Patient #19 was assessed, blood sugar remained at a therapeutic level. The physician was notified for items 1 and 2. Patient #21 received the appropriate dosing once error was detected. LPN #1 received additional training on 9/28/2011 prior to beginning her shift regarding insulin injection sites. 2. All patients have the potential to be affected by medication errors. The hospital medication pass policy contains multiple stages of checks to assist in preventing medication errors. 3. All nurses will receive additional training by October 20, 2011 related to med error prevention including insulin injection sites and double check policy. Annual nurse competencies include medication pass checks. Hospital orientation includes medication pass</p>	10/20/2011	

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	<p>deltoid (2 inches below shoulder in upper arm muscle) for a blood sugar level of 193.</p> <p>Review of the clinical record for Resident # 19 on 9/27/2011 at 11:50 a.m., included diagnoses of, but not limited to; diabetes, removal of hardware total hip left.</p> <p>Review of physician orders, dated 9/20/2011 at 11:00 p.m., indicated "Humalog SQ (subcutaneous) sliding scale AC (before meals) and HS (hour of sleep) for blood sugar levels 151-200 = 3 units, 201-250 = 4 units, 251-300 = 5 units, 301-350 = 6 units, 351-400 = 7 units, over 400 = 8 units."</p> <p>On 9/27/2011 at 11:55 a.m., in an interview with LPN # 1 she indicated that a subcutaneous insulin shot could be given in the "deltoid" muscle.</p> <p>On 9/27/2011 at 12:11 p.m., in an interview with Registered Nurse (RN) # 1, she indicated that a subcutaneous insulin shot could be given "behind arm." When queried if a subcutaneous insulin injection could be given in the deltoid, the RN's</p>		<p>competency checks and observations. The Vitamin C and Calcium were separated in the Diabold dispenser as they are both commonly given medications, both are 500 mg, and both contain a "C". All team members are required to complete error prevention training by December 31, 2011 as part of the hospital-wide safety initiative.4. Med pass audits will be conducted by the Associate Nurse Manager or designee three times per week for four weeks; then two times per week for four weeks. The audit results will be reported to the Quality Council to determine the need for continued written audits. A med error rate less than 2% shall be achieved for a two consecutive four week periods before written audits can be discontinued at the Quality Council's determination.</p>		

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	<p>response was "no."</p> <p>On 9/27/2011 at 12:23 p.m., in an interview with LPN # 3, she indicated that a subcutaneous insulin injection could be given in the "back of arm." When asked if a subcutaneous insulin injection could be given in the deltoid, the LPN's response was "you would not give it in the deltoid."</p> <p>On 9/29/2011 at 10:50 a.m., the Administrator presented the facility's current policy and procedure on "Subcutaneous Injection," Review of the facility's policy and procedure on subcutaneous injection under procedure # 10 indicated "outer aspect of both arms" and the on-line visual from BD Diabetes that the facility used, indicated "The back of the upper arms."</p> <p>On 9/29/2011 at 11:00 a.m., review of LPN # 1's training and in-services, indicated that on 2/21/2011 she was observed by RN # 2 to be competent with injections.</p> <p>2. On 9/27/2011 at 4:10 p.m. during observation of the medication pass for</p>				

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	<p>Resident # 14, LPN # 2 administered a vitamin C 500 milligram (m.g.) whole tablet to Resident # 14. Record review of the resident's medication orders lacked an order for vitamin C.</p> <p>In an interview on 9/27/2011 at 4:15 p.m., LPN # 2 indicated that she thought it was a calcium pill. Pharmacist # 1 indicated that the Vitamin C was stocked in the Med-Select (medication administration machine) slot right behind where the calcium pills were stocked. Pharmacist # 2 pulled a calcium pill out of the Med-Select for LPN # 2 to administer to the resident as ordered. LPN # 2 called the physician and let him know that resident received a Vitamin C.</p> <p>Review of the clinical record for Resident # 14 on 9/27/2011 at 4:20 p.m., indicated diagnoses of, but not limited to; right total hip arthroplasty, mild mental retardation secondary to pediatric infection.</p> <p>Review of the physicians orders, dated 9/16/2011, indicated, but is not limited to; calcium carbonate 250 m.g. with vitamin D 125 units tablet by mouth (po) every day. The Medication Administration Record (MAR) indicated that pharmacy</p>				

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	<p>substituted calcium carbonate with vitamin D 500/200 tablet, 1/2 tablet to be given po every evening at supper.</p> <p>3. On 9/28/2011 at 9:25 a.m., during observation of the medication pass for Resident # 21, LPN # 1 confirmed medications for administration including, but not limited to; metformin 500 m.g., 2 tablets outside the resident's room. LPN # 1 then opened the medications at the resident's bedside explaining dosage and what drug each of them were. LPN # 1 was in the process of administration of the medication when the LPN #1 was asked if there was supposed to be 2 metformin in the medication cup. LPN # 1 indicated there was supposed to be 2 metformin pills and upon inspection of medication cup there was only one. LPN # 1 indicated that she had not noticed that there was only one and proceeded to look for it. The missing medication could not be found. LPN # 1 had Pharmacist # 1 pull a missing dose from the Med-Select.</p> <p>Review of the clinical record for Resident # 21 on 9/28/2011 at 9:40 a.m., indicated diagnoses of, but not limited to; right total knee replacement. Review of the physicians order, dated 9/17/2011, indicated, but was not limited to;</p>				

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

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FORM APPROVED

OMB NO. 0938-0391

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	metformin 500 m.g., 2 tabs, by mouth every a.m.  3.1-48(c)(1)				