

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/23/2014
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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260
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F000000	<p>This visit was for the investigation of complaints: IN00148809, IN00148878, and IN00149297.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the investigation of complaint IN00144974 completed on March 21, 2014.</p> <p>Complaint IN00148809 - Substantiated - Federal/State deficiencies related to the allegations are cited at F325 and F327.</p> <p>Complaint IN00148878 - Substantiated - No deficiencies.</p> <p>Complaint IN0000149297 - Substantiated - Federal/State deficiencies related to the allegations are cited at F425.</p> <p>Survey dates: May 20, 21, 22 and 23, 2014.</p> <p>Facility number: 000195 Provider number: 155298 AIM number: 100267690</p> <p>Survey team: Gloria Bond, R.N. -- Team Coordinator Michelle Hosteter, R.N.</p>	F000000	<p><i>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></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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F000325 SS=G	<p>Mary Jane Fischer, R.N. (5/21, 5/22 and 23, 2014).</p> <p>Census bed type: SNF/NF--67 Total --67</p> <p>Census payor type: Medicare--13 Medicaid--49 Other--5 Total--67</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on May 30, 2014.</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview the facility failed to ensure the</p>	F000325	Immediate corrective action(s) for those Residents affected by	06/08/2014	

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	<p>nutrition needs of dependent residents, in that when residents required extensive assistance with nutrition, the facility failed to ensure the nutrition needs for 1 of 3 residents reviewed. (Residents "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 05-21-14 at 11:00 a.m. Diagnoses included, but were not limited to cerebral vascular accident, hemiplegia, upper limb amputation, hypothyroidism, Alzheimer's disease, depressive disorder, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS (Minimum Data Set) assessment, dated 01-02-14, indicated the resident required extensive assistance with eating. The resident's weight was noted at 178 lbs (pounds). The resident had physician orders for a regular diet.</p> <p>A review of the resident MDS (Minimum Data Set) assessment, dated 03-27-14, indicated the resident continued to require extensive assistance with eating and now weighed 172 lbs.</p> <p>A review of the resident's current plan of</p>		<p>the deficient practice; Resident A has had considerable challenges with poor consumption that have been monitored by the facility for years. Based on a facility nurse's observation on 4/19/14, he was transferred to the acute hospital for continued treatment and services. Plan /Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken; Meal intake patterns were audited to identify other Residents with a recent pattern of reduced nutritional intake. Residents identified at risk for weight loss were reviewed by the Registered Dietitian to ensure existing plans of care were in alignment with Advanced Directives and Physician's Orders. Facility measures and systemic changes to ensure the deficient practice does not recur; Nursing Staff have been educated by the Director of Nursing or her designee on the importance of meal intake, interventions to promote optimal intake, and weight/intake notification requirements. Any Nursing Staff missing the initial education opportunities will be educated prior to their next shift. Nursing management will run a report via the electronic documentation system. The interdisciplinary team will review residents with</p>		

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	<p>care originally dated 11-08-12 indicated the resident had "poor intake." A Goal to this problem/concern indicated the need of encouragement to consume 50 % - 75 % meal intake times three months. Approaches to this plan of care included "Diet as ordered: regular with no raw vegetables, and fortified foods, snacks/supplements ordered, Honor food/fluid preferences, notify MD [Medical Doctor] of significant weight change. RD [registered dietician] evaluation as ordered."</p> <p>A review of the "Intake and Output" record for April 2014 indicated the resident's intake started to decline on or around April 14, 2014. The record indicated the following consumption percentages:</p> <p>"04-14-14 breakfast 25%, lunch 25%, dinner 50%."</p> <p>"04-15-14 breakfast bites, lunch bites, dinner 50 %."</p> <p>"04-16-14 resident refused breakfast, lunch and dinner."</p> <p>"04-17-14 breakfast 25%, lunch - blank, dinner 25%."</p> <p>"04-18-14 breakfast 25 %, lunch 25%, dinner 50%."</p> <p>"04-19-14 resident refused breakfast and lunch."</p>		<p>significant weight loss or a decline in meal intake issues. Appropriate care planning will be addressed in accordance with identified needs. Issues identified with noncompliance will result in additional education and/or disciplinary action in accordance with facility policies.</p> <p>Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process; Nursing management will run a report via the electronic documentation system three times a week for the first four weeks, weekly for four weeks, and then monthly thereafter. The inter-disciplinary team will review residents with significant weight loss or a decline in meal intake issues. Appropriate care planning will be addressed in accordance with identified needs. A monthly audit will be completed by the Director of Nursing or her designee to determine if significant weight variances have been addressed. As part of the ongoing Quality Improvement process, issues identified related to significant weight loss will be referred to the monthly Quality Management Committee for problem-analysis, action planning, and additional monitoring needs as indicated.</p>	

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	<p>The Registered dietician note dated 04-18-14 indicated the "resident to have decreased po [by mouth] intakes. Res. [resident] cont. [continues] on a regular with no raw vegetables and fortified foods. PO intakes noted as 35, 30, 35 %. Res. wt. [weight] 170.8 lbs. [pounds] a decrease of 5.5% in 90 days, a decrease of 6.5 % in 180 days. Receives Remeron [an appetite stimulant] 7.5 mg [milligrams] which may help stimulate appetite. Res. was seen by NP [Nurse Practitioner] on 04-15-14 and indicated failure to thrive."</p> <p>A review of the nurses notes, dated 04-19-14 at 8:30 a.m., "Res. [resident] noted by writer to be alert, but non-verbal. Res. mouth dry, unable to take in fluids or food. Res. refused a.m., meal. MD [Medical Doctor] notified of change of condition. Labs ordered. CMP [complete metabolic profile], and CBC [complete blood count] with differential STAT. Family notified. Mouth swabbed with toothette. Will cont. [continue] to monitor... 12:00 p.m. This writer noted res. declining. Labs called to writer chloride noted to be High 123 along with other abnormal values. NP [Nurse Practitioner] notified. Family notified. Received order to send res. over to [name of local area hospital] for eval. [evaluation] and tx. [treatment]. Report</p>			

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	<p>called to ER [emergency room] spoke with charge nurse. 4:45 p.m. Res. being admitted to hospital. Dx. [diagnosis] dehydration."</p> <p>During an interview with licensed nurse #8 on 05-22-14 at 2:00 p.m. "On wound rounds we or I have been noticing a decline in [name of Resident "A"], I'm here on Thursday and weekend's, I watch and pay attention, because that's what I do. I could see the weight loss and the decline. I heard [name of licensed nurse #9] telling the floor nurse that [name of Resident "A"] hadn't eaten. She [licensed nurse #9] is visual and on rounds and she had told the floor nurse that he hadn't eaten and noticed he hadn't eaten prior to that. His mouth was so dry he couldn't suck on the straw - I took the straw and got some water and drops on his tongue and he just couldn't get enough."</p> <p>During an interview on 05-22-14 at 4:30 p.m., the resident's family member indicated the resident required help with his meal, and at times, she would come to the facility to find the resident in bed, and his tray in front of him on the bedside table. "Since his stroke he just needs some help. When I talked with him on right before they sent him out to the hospital, he was hard to understand and kept saying he was thirsty. I was</p>						

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	<p>bringing him some greens and some of the other foods he likes. They just needed to help him."</p> <p>A review of the hospital emergency room notation, dated 04-19-14 indicated the following: "Pt. [patient] presents via EMS [emergency medical system] from ECF [extended care facility] with c/o [complaints of] altered mental status since this AM. Pt. lethargic, unable to answer questions and follow commands at this time. Pt. usually alert and oriented times 4, communicative. Pt is w/c [wheelchair] bound, hx. [history] of right amputation, HTN [hypertension], DM [diabetes mellitus], full code. Pt has not taken any medications today per EMS per staff at Pyramid Point."</p> <p>The hospital Laboratory values dated 04-19-14 indicated the resident's Sodium level was 159 H [high] with normal values at 136 to 145, BUN [blood urea nitrogen] 52 H with normal values at 8 to 26.</p> <p>The hospital "History and Physical," dated 04-19-14 indicated "Chief complaint: confusion, decreased PO [by mouth] intake - admitted from ED [emergency department]. Per reports <sic>, pt has not been eat <sic> or</p>			

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	<p>drinking well for at least a few days. He has progressively declined over the last few days and today was noted to be significantly altered. Pt. is typically oriented and is able to have full conversations, however, he is now lethargic and hasn't been speaking much at all per his [family member].</p> <p>Impression/Assessment: AKI [acute kidney injury] BUN 52 pre-renal in setting at decreased PO intake. Pt. received NS [normal saline] 2 L [liters] in ED continue IVF [intravenous fluids]. Hyponatremia - Na [sodium] 159 likely secondary to decreased in free water intake. Calculated water deficit of about 5 liters. IVF D5W [dextrose 5% water] at 100 ml/hr [milliliter per hour] q [every] 6 hours for 24 hours then q 12 hours."</p> <p>The hospital physician report, dated 04-19-14 at 2030 (8:30 p.m.) indicated the resident was diagnosed with "1. acute delirium, 2. severe hyponatremia, 3. acute kidney injury - profound dehydration."</p> <p>The hospital indicated the resident weighed 158.4 lbs at the time of admission a loss of approximately 13.6 lbs since the first of April. The resident was diagnosed with "dysphagia NPO [nothing by mouth] for now secondary to</p>			

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F000327 SS=G	<p>AMS [altered mental status] and increased aspiration risk."</p> <p>During an interview on 05-22-14 at 9:00 a.m., employee #10 was interviewed about the resident and the lack of food consumption. The staff member responded "Oh that's just the way he is."</p> <p>This Federal Tag relates to complaint IN00148809.</p> <p>3.1-46(a)(1)</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on observation, record review and interview the facility failed to ensure the hydration needs of dependent residents, in that when residents required extensive assistance with hydration needs, the facility nursing staff failed to provide the required hydration to meet the needs for 2 of 3 residents reviewed. (Residents "A" and "E").</p> <p>Findings include:</p> <p>1. The record for Resident "A" was</p>	F000327	<p>Immediate corrective action(s) for those Residents affected by the deficient practice; Based on a facility nurse's observation on 4/19/14, he was transferred to the acute hospital for continued treatment and services. Resident E has had her hydration status reviewed by the Registered Dietitian and her care plan was updated as needed.</p> <p>Plan /Process to identify other residents potentially affected by the same deficient practice and corrective action(s) to be taken; Residents identified at risk</p>	06/08/2014			

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	<p>reviewed on 05-21-14 at 11:00 a.m. Diagnoses included, but were not limited to cerebral vascular accident, hemiplegia, upper limb amputation, hypothyroidism, Alzheimer disease, depressive disorder, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident MDS (Minimum Data Set) assessment, dated 03-27-14, indicated the resident required extensive assistance with eating.</p> <p>A review of the resident's current plan of care originally dated 11-08-12 indicated the resident had "poor intake." A Goal to this problem/concern indicated the resident "will have no s/s [signs and symptoms] of altered hydration times 3 months, and will consume as much oral intake as desired/tolerated times 3 months."</p> <p>A review of the "Intake and Output" record for April 2014 indicated the resident's intake started to decline on or around April 14, 2014. The record indicated the following consumption percentages: "04-14-14 breakfast 25%, lunch 25%, dinner 50%." "04-15-14 breakfast bites, lunch bites,</p>		<p>for dehydration were reviewed by the Registered Dietitian or Certified Dietary Manager to ensure existing plans of care were in alignment with Advanced Directives and Physician's Orders. Facility measures/systemic changes made to ensure the deficient practice does not recur; The Director of Nursing or her designee will re-educate C.N.A.'s on providing adequate fluids, interventions to optimize intake, and reporting poor fluid intake. The Director of Nursing or her designee will re-educate the Nurses on providing adequate fluids in accordance with assessed needs, properly assessing signs of dehydration, monitoring intake and output as indicated, and promptly notifying physicians of hydration issues. Issues identified with noncompliance will result in additional education and/or disciplinary action in accordance with facility policies. Facility plan to monitor the process and sustain compliance / Integrate into the Quality Assurance System; The Director of Nursing or her designee will review meal intake records to identify residents at risk for dehydration and update plans of care as indicated three times a week for four weeks, weekly for four weeks, then monthly thereafter. The Director of Nursing or her designee will be responsible for identifying audit</p>	

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	<p>dinner 50 %."</p> <p>"04-16-14 resident refused breakfast, lunch and dinner."</p> <p>"04-17-14 breakfast 25%, lunch - blank, dinner 25%.</p> <p>"04-18-14 breakfast 25 %, lunch 25%, dinner 50%."</p> <p>"04-19-14 resident refused breakfast and lunch."</p> <p>A review of the nurses notes, dated 04-19-14 at 8:30 a.m., Res. [resident] noted by writer to be alert, but non-verbal. Res. mouth dry, unable to take in fluids or food. Res. refused a.m. meal. MD [Medical Doctor] notified of change of condition. Labs ordered. CMP [complete metabolic profile], and CBC [complete blood count] with differential STAT. Family notified. Mouth swabbed with toothette. Will cont. [continue] to monitor. 12:00 p.m. This writer noted res. declining. Labs called to writer chloride noted to be High 123 along with other abnormal values. NP [Nurse Practitioner] notified. Family notified. Received order to send res. over to [name of local area hospital for eval. [evaluation] and tx. [treatment]. Report called to ER [emergency room] spoke with charge nurse. 4:45 p.m. Res. being admitted to hospital. Dx. [diagnosis] dehydration."</p>		issues and reporting trends to the monthly quality management committee for problem analysis, remedial planning, and additional monitoring needs as indicated.	

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	<p>During an interview with licensed nurse #8 on 05-22-14 at 2:00 p.m. "On wound rounds we or I have been noticing a decline in [name of Resident "A"], I'm here on Thursday and weekend's, I watch and pay attention, because that's what I do. I could see the weight loss and the decline. I heard [name of licensed nurse #9] telling the floor nurse that [name of Resident "A"] hadn't eaten. She [licensed nurse #9] is visual and on rounds and she had told the floor nurse that he hadn't eaten and noticed he hadn't eaten prior to that. His mouth was so dry he couldn't suck on the straw - I took the straw and got some water and drops on his tongue and he just couldn't get enough."</p> <p>A review of the hospital emergency room notation, dated 04-19-14 indicated the following: "Pt. [patient] presents via EMS [emergency medical system] from ECF [extended care facility] with c/o [complaints of] altered mental status since this AM. Pt. lethargic, unable to answer questions and follow commands at this time. Pt. usually alert and oriented times 4, communicative. Pt is w/c [wheelchair] bound, hx. [history] of right amputation, HTN [hypertension], DM [diabetes mellitus], full code. Pt has not taken any medications today per EMS per staff at Pyramid Point."</p>						

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	<p>The hospital Laboratory values dated 04-19-14 indicated the resident's Sodium level was 159 H [high] with normal values at 136 to 145, BUN [blood urea nitrogen] 52 H with normal values at 8 to 26.</p> <p>The hospital "History and Physical," dated 04-19-14 indicated "Chief complaint: confusion, decreased PO [by mouth] intake - admitted from ED [emergency department]. Per reports <sic>, pt has not been eat <sic> or drinking well for at least a few days. He has progressively declined over the last few days and today was noted to be significantly altered. Pt. is typically oriented and is able to have full conversations, however, he is now lethargic and hasn't been speaking much at all per his [family member]. Impression/Assessment: AKI [acute kidney injury] BUN 52 pre-renal in setting at decreased PO intake. Pt. received NS [normal saline] 2 L [liters] in ED continue IVF [intravenous fluids]. Hyponatremia - Na [sodium] 159 likely secondary to decreased in free water intake. Calculated water deficit of about 5 liters. IVF D5W [dextrose 5% water] at 100 ml/hr [milliliter per hour] q [every] 6 hours for 24 hours then q 12 hours."</p> <p>The hospital physician report, dated</p>			

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	<p>04-19-14 at 2030 (8:30 p.m.) indicated the resident was diagnosed with "1. acute delirium, 2. severe hyponatremia, 3. acute kidney injury - profound dehydration."</p> <p>2. The record review for Resident E was completed on 5/22/14 at 1:00 P.M. Diagnoses included, but were not limited to, vascular dementia, end stage renal disease, and congestive heart failure.</p> <p>The MDS (Minimum Data Set) assessment dated 4/28/14 indicated the resident was moderately cognitively impaired and required extensive assist for eating and drinking.</p> <p>During an observation on 5/21/14 at 9:54 A.M., the resident was observed to have a very dry mouth and had difficulty talking. The resident's water pitcher was across the room on a table that was not within reach of the resident. The resident indicated she wanted some water.</p> <p>During an observation on 5/21/14 at 2:00 P.M., the resident was observed to have the sheet pulled all the way over her head. The bedside table that was not within arm's reach of the resident, had an empty Suplena 8 ounce can with a straw in it that was empty. The water pitcher was observed to be on the table at the</p>			

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	<p>opposite end of the room.</p> <p>During an observation on 5/22/14 at 8:05 A.M., the resident was observed in bed. There was no water at her bedside.</p> <p>The documentation for the resident from 4/22/14 through 5/21/14 indicated fluid consumptions were as follows: 4/22- 360 ml (milliliters) 4/23- 120 ml 4/24- 0 ml 4/25- 960 ml of "other" fluids 4/26- 240 ml 4/27- 120 ml 4/28- 1160 ml 4/29- "Refused" for breakfast and nothing documented for other meals 4/30- 240 ml for "other" fluids 5/1- 360 ml 5/2- 360 ml 5/3- 120 ml 5/4- 180 ml 5/5- 120 ml 5/6- 121 ml 5/7- 240 ml 5/8- 502 ml 5/9- 1050 ml 5/10- 360 ml 5/11- 240 ml 5/12- LOA to hospital 5/14- LOA (Leave of Absence) 5/15- 380 milliliter's 5/16- 280 ml</p>				

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	<p>5/17- 200 ml 5/18- 0 (refused) 5/19- 410 ml 5/20- DNO (Did Not Occur)-0 total 5/21- Refused for lunch none for breakfast</p> <p>The resident's chart indicated the resident was on a renal diet, and was on thin liquids as of 2/4/14 for her nutritional assessment.</p> <p>The 5/22/14 meal tray card indicated, "...Regular Renal diet...Preferences Apple Juice, 2% milk, for the breakfast meal, ...lunch preferences-water... dinner-preferences-water...."</p> <p>The Nutrition care plan dated 5/30/13 with recent revision date of 2/4/14 indicated, "...will have no signs/symptoms of altered hydration x 3 months...honor flood/fluid preferences...."</p> <p>The Director of Nursing indicated on 5/22/14 at 1:35 P.M., that she would expect fluids to be at the bedside on the table where the resident with dementia could reach it even if they needed assistance.</p> <p>On 5/22/14 at 1:45 P.M., LPN # 8 indicated she was able to get the resident</p>				

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	<p>to drink or eat with a bargaining type method. She told the resident she would give the resident coffee after the resident would drink or eat something. She indicated the resident had never been a big eater or drinker, and she had always bargained with her to help to get her to eat or drink. She indicated the resident loved coffee.</p> <p>LPN #8 also indicated she expected the CNA (Certified Nurses Aide) to assist those residents who cannot help themselves with eating or drinking. She indicated that each time the CNA's make rounds in the residents rooms, they should offer fluids to those resident's needing help.</p> <p>LPN #8 indicated the documentation for fluids consumed by the the residents would be documented by the CNA in their headset. She indicated that the water pitchers are filled at least two times a shift and the pitchers of water should be left at the bedside so the resident can access them when they need them.</p> <p>The MAR (Medication Administration Record) for May indicated the resident was on Lasix (a medication that rids the body of extra water) 20 milligrams from 4/20/14 through 5/12/14 when she went out to the hospital.</p>						

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F000425 SS=E	<p>The resident had a physician's order dated 5/15/14, after the resident was placed on hospice to not perform labs, so the hydration status relating to labs was unable to be monitored.</p> <p>This Federal Tag relates to complaint IN00148809.</p> <p>3.1-46(b)</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 provides consultation on all aspects of the provision of pharmacy services in the facility.</p>			
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	<p>Based on record review and interview the facility failed to ensure the availability of pharmaceuticals, in that when residents had specific orders for medication, the facility nursing staff failed to ensure the residents received the medications as ordered. This deficient practice affected 3 of 7 sampled residents. (Residents "C", "B", and "E").</p> <p>Findings include:</p> <p>1. Resident "C" had physician order, dated 02-04-14 for omeprazole (a medication used for symptoms of gastroesophageal reflux disease) 20 mg (milligrams) one capsule, once daily 30 minutes to 1 hour before a meal. A review of the May 2014 Medication Administration record indicated the resident did not receive the medication on 05-02-14 at 6:00 a.m. due to "medication availability issue."</p> <p>In addition the resident had a physician order dated 02-04-14 for Docusate Sodium (a stool softner). On 05-09-14 the medication wasn't given and the "reason" indicated on the medication sheet indicated "medication availability issue."</p> <p>An order dated 03-21-14 for Diazepam 5 mg (an antianxiety medication), 1 tablet by mouth once daily. The medication</p>	F000425	<p>Immediate corrective action(s) for those Residents affected by the alleged deficient practice; Medications for Resident's B, C, and E were made available. Resident C's Valium was discontinued. Plan /Process to identify other residents potentially affected by the same alleged deficient practice and corrective action(s) to be taken; The Director of Nursing coordinated a facility-wide review on 5/27/14 to identify drug supply issues and ensure medications were readily available. Facility measures and systemic changes to prevent recurrence; Licensed Nurses received training on medication availability issues and expected action steps to facilitate timely medication administration as ordered. Issues identified with the timely provision of medication will result in additional nurse education and/ or disciplinary action in accordance with facility policies. Facility plan to monitor corrective actions & sustain compliance; Integrate QA Process; The Director of Nursing or her Designee will review the "medication not administered report" via the electronic medication administration record three times a week for four weeks, and weekly thereafter. Each month, the Director of Nursing or her designee will be responsible for monitoring medication availability</p>	06/08/2014			

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	<p>administration record indicated the resident did not receive the medication on 05-17-14 at 9:00 a.m., 05-18-14 at 9:00 a.m., 05-19-14 at 9:00 a.m., and again on 05-21-14 at 9:00 a.m. The "reason" the nurse documented the resident did not receive the prescribed medication due to "medication availability issue."</p> <p>The resident also had physician orders, originally dated 05-16-14, for Acetylcysteine 100 mg/ml (milliliters) - inhale two times a day. The medication Administration record indicated the resident did not receive the medication on 05-16-14 at 8:00 p.m., due to "Other: Pharmacy still to supply," and did not receive the medication on 05-17-14 at 6:00 a.m., due to "Other: Pharmacy still waiting for supply."</p> <p>2. Resident B's record was reviewed on 5/21/2014 at 2 P.M. Diagnoses included, but were not limited to, osteoarthritis, localized, not specified, shoulder region, and chronic pain.</p> <p>The resident's May 2014, Medication Administration Record (MAR) indicated the resident was scheduled to receive the pain medication, acetaminophen 500 mg, 2 tablets (1000 mg) by mouth 2 times per day. She did not receive her scheduled pain medication on 5/17/14 and on</p>		and referring identified issues to the QA committee for problem analysis, action planning, and additional monitoring needs as indicated.				

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	<p>5/18/14.</p> <p>Resident B's MAR indicated the following:</p> <p>5/17/14 9:00 a.m.-- not administered--acetaminophen 500 mg tablet. SIG (signa or dispense): give 2 tablets (1000 mg) by oral route 2 times per day--medication availability issue.</p> <p>5/17/14 5:00 p.m.--not administered--acetaminophen 500 mg tablet. SIG: give 2 tablets (1000 mg) by oral route 2 times per day--medication availability issue.</p> <p>5/18/14 9:00 a.m.--not administered--acetaminophen 500 mg tablet. SIG: give 2 tablets (1000 mg) by oral route 2 times per day--medication availability issue.</p> <p>5/18/14 5:00 p.m.--not administered--acetaminophen 500 mg tablet. SIG: give 2 tablets (1000 mg) by oral route 2 times per day--medication availability issue.</p> <p>In an interview on 5/22/14 at 11:59 A.M., the DON (Director of Nursing) indicated the staff is instructed to contact the physician if a medication is not available to receive a hold order. She indicated she did not know why this common pain medication was not available.</p> <p>3. The record review for Resident E was completed on 5/22/14 at 1:00 P.M. Diagnoses included, but were not limited</p>			

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	<p>to, vascular dementia, end stage renal disease, and congestive heart failure.</p> <p>The MAR (Medication Administration Record) for April 2014 indicated, "...4/26/14 and 4/29/14... Suplena 1 can three times daily not given due to medication availability issue..."</p> <p>The MAR for May 2014 indicated, "...Pantaprozole 40 milligrams by mouth twice daily not given at 4:00 P.M., due to medication availability issue...Suplena 1 can three times daily not given due to medication availability issue 5/15/14 at 5:00 P.M...."</p> <p>This Federal Tag relates to complaint IN00149297.</p> <p>3.1-25(a)</p>						