

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 10/01/2015
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NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00182474.</p> <p>Complaint IN00182474 - Federal/State deficiency related to the allegations is cited at F282, F309, F425 and F520.</p> <p>Survey dates: September 30, 2015 and October 1, 2015</p> <p>Facility number: 011045 Provider number: 155698 AIM number: 200380790</p> <p>Census bed type: SNF: 48 SNF/NF: 18 Residential: 69 Total: 135</p> <p>Census payor type: Medicare: 35 Medicaid: 18 Other: 82 Total: 135</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00182474) Survey on October 1, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial 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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F 0282 SS=D Bldg. 00	<p>QR completed by 11474 on October 6, 2015.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review, the facility failed to ensure the physician medication orders were followed as written for 2 of 4 residents whose physician orders were reviewed. (Resident C and Resident D)</p> <p>Findings include:</p> <p>1. The clinical record for Resident C was reviewed on 9/30/15 at 10:14 a.m. Diagnoses for Resident C included, but were not limited to, hypertension, peripheral vascular disease, chronic obstructive pulmonary disease, hypothyroidism and after care for right total hip replacement. The Admission Minimum Data Set (MDS), dated 9/22/15, indicated Resident C was cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 out of 15.</p>	F 0282	<p>F 282</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident C and Resident D have been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all new admissions in the last 24 hours to ensure the physician medication orders were followed as written.</p>	10/31/2015

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	<p>Review of the nursing notes, dated 8/29/15 at 11:00 a.m., indicated Resident C arrived to the facility by ambulance with a daughter at the bedside.</p> <p>Review of the Nursing Admission Assessment, dated 8/29/15 at 11:00 a.m., indicated Resident C had "as needed" and scheduled pain medication ordered. Resident C indicated the pain was severe and constant. The assessment lacked a numerical value for Resident C's pain at that time.</p> <p>Review of the physician orders, dated 8/29/15, indicated Resident C had a physician order for oxycodone IR (pain medication) 5 mg every 3 (three) hours "as needed" for mild pain. Resident C also had an order for oxycodone 10 mg every 3 (three) hours "as needed" for severe pain. Resident C had a routine order for ultram (pain medication) 50 mg every 6 (six) hours.</p> <p>Review of the Medication Administration Record for 8/2015 indicated Resident C received the ultram as ordered by the physician every 6 (six) hours at 6:00 am, 12:00 p.m., 6:00 p.m. and 12:00 a.m. The first dose was administered on 8/29/15 at 12:00 p.m.</p>		<p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1). Medication Orders and Receiving from Pharmacy 2). Emergency Pharmacy Services and Emergency Kits 3). Admission Assessment and Data Collection 4). Clinical Documentation Systems 5). Trilogy Health Services for Admission and Discharges in Matrix</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review new admissions to ensure the following: 1). physician medication orders were followed as written</p> <p>2). medications were administered in a timely manner 3). medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration. 4). If medication is needed before delivery, Emergency Drug Kit</p>	

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	<p>Review of the PRN (as needed) Medication Tracking sheet for 8/2015 indicated the resident rated her pain 8/10 on a 1-10 pain scale at 3:45 p.m. on 8/29/15 and was medicated with oxycodone 5 mg, 4 hours after the resident was admitted.</p> <p>Review of the Pharmacy Admitting Face Sheet, dated 8/29/15, indicated the medication orders were faxed to the pharmacy at 2:17 p.m., 3 hours after the resident was admitted.</p> <p>Review of the narcotic EDK (emergency drug kit) list on 9/30/15 at 4:00 p.m., indicated oxycodone 5 mg tablets were available.</p> <p>During an interview on 10/1/15 at 8:30 a.m., Resident C indicated she had been in severe pain due to cellulitis on the original admission date of 8/29/15. Resident C indicated she had asked for the "as needed" pain medication oxycodone but was told it was not available. "My daughter had to go to Lapel to get a script from my doctor, get it filled at the drug store and brought it here. They gave me some other medication but I told them I needed the oxycodone because it works. I think there was a problem because it was at shift change here. "</p>		<p>(EDK) is utilized 5). If medication is needed and not available in EDK, the back up pharmacy will be utilized 6). If the medication is needed and not available in the EDK and the back up pharmacy delivery is not expected to be timely, the MD will be notified and request a alternative medication order that is stocked in the EDK until the prescribed medications are received from pharmacy. 7). Documentation of MD notification if alternative medication needed is in place 8). Documented Matrix admission arrival time is correct 9). Documented admission assessment time is in place and correct</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>During an interview on 10/1/15 at 11:30 a.m., the Clinical Support Nurse reviewed Resident C's clinical record and indicated Resident C's medications should have been ordered more timely and should have been available in the facility.</p> <p>2. The clinical record for Resident D was reviewed on 9/30/15 at 10:22 a.m. Diagnoses for Resident D included, but were not limited to, chronic obstructive pulmonary disease, hypertension, total right knee replacement after care, obesity and a history of transient ischemic accidents.</p> <p>Review of the face sheet indicated Resident D was admitted on 9/9/15 at 11:00 a.m.</p> <p>Review of the Nursing Admission Assessment, dated 9/9/15 at 11:00 a.m., indicated Resident D had "as needed" pain medication ordered. Resident D indicated the pain was 5/10 on a numeric pain scale of 1 (one) to 10 (ten).</p> <p>Review of the physician orders, dated 9/9/15, indicated the following: Zetia (hypercholesterolemia) 10 mg at bedtime Lasix (diuretic) 20 mg daily</p>			

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	<p>Glucosamine-Chond (vitamin supplement) daily</p> <p>Hydralazine (anti hypertensive) 100 mg twice daily</p> <p>Mobic (osteoarthritis) 15 mg daily</p> <p>Multivitamin (supplement) daily</p> <p>Bystolic (anti hypertensive) 2.5 mg at bedtime</p> <p>Omega 3 (hypercholesterolemia) 3,000 mg daily</p> <p>Vitamin C (supplement) 1000 mg daily</p> <p>Aspirin (stroke prevention) 81 mg daily</p> <p>Citracal/Vitamin D (supplement) daily</p> <p>Cetirizine HCL (chronic allergies) 10 mg daily</p> <p>Plavix (antiplatelet) 75 mg daily</p> <p>Dicyclomine HCL (osteoarthritis) 20 mg 4 (four) times daily</p> <p>Nexium (antiulcer) 40 mg twice daily</p> <p>K-Dur (potassium supplement) 20 mEq daily</p> <p>Simvastatin (antilipemics) 5 mg at bedtime</p> <p>Restoril (hypnotic) 30 mg at bedtime</p> <p>Calan (anti-hypertensive) 120 mg at bedtime</p> <p>Calan SR (anti-hypertensive) 240 mg daily</p> <p>Ultram (pain medication) 50 mg every 6 (six) hours as needed for moderate pain</p> <p>Ultram (pain medication) 100 mg every 6(six) hours as needed for severe pain</p> <p>Tylenol 650 mg every 4 (four) hours as needed for mild pain</p>			

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	<p>Review of the Medication Administration Record for September 2015 indicated Resident D did not receive the following medication due to the medication not being available at that time: Dicyclomina HCL 20 mg supper and 9:00 p.m. doses Nexium 40 mg supper dose Restoril 30 mg bedtime dose Zetia 10 mg 9:00 p.m. dose Hydralazine 100 mg supper dose Multivitamin supper dose Bystolic 2.5 mg 9:00 p.m. dose Amitriptyline HCL 50 mg 9:00 p.m. dose Citracal/Vitamin D supper dose</p> <p>Review of the nursing notes indicated the clinical record lacked any admission note. The clinical record lacked any nursing notes other than a note, dated 9/10/15 at 4:15 a.m., indicating Resident D had left the facility AMA (against medical advice). The nursing notes lack any indication the physician had been notified regarding the unavailable medications and request for alternative medications until the prescribed medications were received from pharmacy.</p> <p>During an interview on 10/1/15 at 11:30 a.m., the Clinical Support Nurse indicated the following: "A note should</p>			

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F 0309 SS=D Bldg. 00	<p>have been written if there was any difficulty receiving medications from pharmacy and the alternative plan for obtaining medications. If the resident is having pain or significant medical concerns, the physician should be notified and informed if medications are not available and updated on what is available through our EDK (emergency drug kit)."</p> <p>This federal tag relates to Complaints IN00182474.</p> <p>3.1-35(g)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on clinical record review and interview, the facility failed to ensure medications were administered in a timely manner for 2 of 4 residents reviewed. (Resident C and Resident D)</p> <p>Findings include:</p>	F 0309	<p>F 309</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient</p>	10/31/2015	

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	<p>1. During an interview on 9/30/15 at 1:34 p.m. Resident D indicated she had asked for pain medication repeatedly upon admission to the facility. "They kept telling me they were waiting for the scripts from pharmacy. I didn't even get my blood pressure medications."</p> <p>The clinical record for Resident D was reviewed on 9/30/15 at 10:22 a.m. Diagnoses for Resident D included, but were not limited to, chronic obstructive pulmonary disease, hypertension, total right knee replacement after care, obesity and a history of transient ischemic accidents.</p> <p>Review of the face sheet indicated Resident D was admitted on 9/9/15 at 11:00 a.m. Review of the Nursing Admission Assessment, dated 9/9/15, indicated Resident D was assessed at 4:00 p.m. It indicated Resident D was alert and oriented and had prn (as needed) and scheduled pain medications ordered. Resident D indicated the pain was rated 5/10 (five) on a numeric pain scale of 1 (one) to 10 (ten).</p> <p>Review of the nursing notes indicated the clinical record lacked any admission note.</p> <p>Review of the EDK (emergency drug kit)</p>		<p>practice: Resident C and Resident D have been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all new admissions in the last 24 hours to ensure the medications were administered in a timely manner.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1). Medication Orders and Receiving from Pharmacy 2). Emergency Pharmacy Services and Emergency Kits 3). Admission Assessment and Data Collection 4). Clinical Documentation Systems 5). Trilogy Health Services for Admission and Discharges in Matrix</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per</p>	

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	<p>list on 9/30/15 at 4:00 p.m., indicated none of Resident D's blood pressure medications were available in the facility.</p> <p>Review of the pharmacy delivery sheet, dated 9/10/15, indicated all of Resident D's medication was delivered to the facility and signed for by LPN #3 at 3:15 a.m.</p> <p>During an interview on 10/1/15 at 11:30 a.m., the Clinical Support Nurse indicated the following: "It would be my recommendation that the admission nursing assessment is completed, per policy within 24 hours; however, the assessment should be an on going process that starts at the time of admission. The nurse should have written nursing notes to indicate the on going assessment process. Certain assessments should be done immediately upon admission such as pain, vitals signs, skin and any immediate needs." Policies related to medication ordering from pharmacy and documentation were requested at this time. No pharmacy policies were provided.</p> <p>During an interview on 9/30/15 at 3:13 p.m., LPN #2 indicated the following: "Her medications (Resident D) had been ordered from the back up pharmacy [name of pharmacy]. She asked about</p>		<p>week times 8 weeks, then monthly times 4 months to ensure compliance: Review new admissions to ensure the following: 1). physician medication orders were followed as written</p> <p>2). medications were administered in a timely manner</p> <p>3). medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration. 4). If medication is needed before delivery, Emergency Drug Kit (EDK) is utilized 5). If medication is needed and not available in EDK, the back up pharmacy will be utilized 6). If the medication is needed and not available in the EDK and the back up pharmacy delivery is not expected to be timely, the MD will be notified and request a alternative medication order that is stocked in the EDK until the prescribed medications are received from pharmacy. 7). Documentation of MD notification if alternative medication needed is in place 8). Documented Matrix admission arrival time is correct 9). Documented admission assessment time is in place and correct</p>		

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	<p>her medicines and I told her we were waiting to get them from [name of pharmacy]. I even called our pharmacy and they said they were still processing the orders and getting them ordered for the back up pharmacy. It can take up to 4-6 hours to get the medications from the back up pharmacy sometimes. Sometimes it doesn't take that long. I passed it onto the third shift nurse that the medications had not come and she should give them to her as soon as they came in. I don't think her medications were available from our EDK (emergency drug kit)."</p> <p>During an interview on 10/1/15 at 7:46 a.m., LPN #3 indicated she administered Resident D's bedtime blood pressure medication at 2:00 a.m. "She called me in at about 2:00 a.m. and asked for pain medication. I said sure. I went to check and she could have Tramadol. I called and got authorization to take it from the EDK (emergency drug kit). She said thank you and said it was the first pain medication she had gotten. I asked if she had asked for pain medication before and she said she had, but no one had given her anything. She said that she had been waiting all day for her blood pressure medication and they kept telling her it would be in later. So I checked the MAR (Medication Administration Record). I</p>		The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.		

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	<p>found one blood pressure medication I could give her in the top drawer. When the back up came in they only backed up some of her medicine. The medicine was scheduled for HS (bedtime), but I gave it anyway to appease her. She was upset and I was trying to calm her down. I am not sure why she didn't get it when it came in. The medicines I found had come in before my shift, but I am not sure when. I didn't sign for them. I don't know why it took so long for them to get her meds in. Sometimes we wait a long time for meds from the back up when we get a new resident. I know that when I come in at 11:00 p.m. a lot of times, the second shift nurse will tell me they have been calling the pharmacy [name of pharmacy] for 2-3 hours and the meds still haven't arrived."</p> <p>2. The clinical record for Resident C was reviewed on 9/30/15 at 10:14 a.m. Diagnoses for Resident C included, but were not limited to, hypertension, peripheral vascular disease, chronic obstructive pulmonary disease, hypothyroidism and after care for right total hip replacement. The Admission Minimum Data Set (MDS), dated 9/22/15, indicated Resident C was cognitively intact with a BIMS (Brief Interview for Mental Status) of 15 out of 15.</p>			

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	<p>Review of the physician orders, dated 8/29/15, indicated Resident C had a physician order for oxycodone IR (pain medication) 5 mg every 3 (three) hours "as needed" for mild pain. Resident C also had an order for oxycodone 10 mg every 3 (three) hours "as needed" for severe pain. Resident C had a routine order for ultram (pain medication) 50 mg every 6 (six) hours.</p> <p>Review of the Medication Administration Record for 8/2015 indicated Resident C received the ultram as ordered by the physician every 6 (six) hours at 6:00 am, 12:00 p.m., 6:00 p.m. and 12:00 a.m. The first dose was administered on 8/29/15 at 12:00 p.m.</p> <p>Review of the PRN (as needed) Medication Tracking sheet for 8/2015 indicated the resident rated her pain 8/10 on a 1-10 pain scale at 3:45 p.m. and was medicated with oxycodone 5 mg, 4 hours after the resident was admitted. Upon evaluation of the medication's effectiveness, the resident rated the pain at a 3 on the numeric pain scale.</p> <p>Review of the medication list in the narcotic EDK (emergency drug kit) indicated ultram and oxycodone were both available to the facility.</p>			

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NAME OF PROVIDER OR SUPPLIER BETHANY POINTE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 1707 BETHANY RD ANDERSON, IN 46012
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F 0425 SS=D Bldg. 00	<p>Review of a current policy undated titled "Clinical Documentation Systems" provided by the Clinical Support Nurse on 10/1/15 at 2:30 p.m., indicated the following: "Procedure: An initial assessment will be initiated with a temporary care plan developed within 24 hours and completed within 72 hours of admission. Ongoing assessments will be completed daily for skilled residents and monthly for non-skilled residents. In addition to these requirements and assessment will be completed with episodic events such as an incident or a change in medical condition...."</p> <p>This Federal tag relates to Complaint IN00182474.</p> <p>3.1-37(a)</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>			

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	<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. Based on interview and record review, the facility failed to ensure medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration. This deficient practice affected 1 out of 4 residents reviewed. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 9/30/15 at 10:22 a.m. Diagnoses for Resident D included, but were not limited to, chronic obstructive pulmonary disease, hypertension, total right knee replacement after care, obesity and a history of transient ischemic accidents.</p> <p>Review of Resident D's face sheet indicated Resident D was admitted on 9/9/15 at 11:00 a.m. Review of the physician orders, dated 9/9/15, indicated the following:</p>	F 0425	<p>F 425</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident C and Resident D have been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all new admissions in the last 24 hours to ensure the medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration.</p> <p>Measures put in place and systemic changes made to</p>	10/31/2015

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	<p>Zetia (hypercholesterolemia) 10 mg at bedtime</p> <p>Lasix (diuretic) 20 mg daily</p> <p>Glucosamine-Chond (vitamin supplement) daily</p> <p>Hydralazine (anti hypertensive) 100 mg twice daily</p> <p>Mobic (osteoarthritis) 15 mg daily</p> <p>Multivitamin (supplement) daily</p> <p>Bystolic (anti hypertensive) 2.5 mg at bedtime</p> <p>Omega 3 (hypercholesterolemia) 3,000 mg daily</p> <p>Vitamin C (supplement) 1000 mg daily</p> <p>Aspirin (stroke prevention) 81 mg daily</p> <p>Citracal/Vitamin D (supplement) daily</p> <p>Cetirizine HCL (chronic allergies) 10 mg daily</p> <p>Plavix (antiplatelets) 75 mg daily</p> <p>Dicyclomine HCL (osteoarthritis) 20 mg 4 (four) times daily</p> <p>Nexium (antiulcer) 40 mg twice daily</p> <p>K-Dur (potassium supplement) 20 mEq daily</p> <p>Simvastatin (antilipemic) 5 mg at bedtime</p> <p>Restoril (hypnotic) 30 mg at bedtime</p> <p>Calan (anti-hypertensive) 120 mg at bedtime</p> <p>Calan SR (anti-hypertensive) 240 mg daily</p> <p>Ultram (pain medication) 50 mg every 6 (six) hours as needed for moderate pain</p> <p>Ultram (pain medication) 100 mg every</p>		<p>ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1). Medication Orders and Receiving from Pharmacy 2). Emergency Pharmacy Services and Emergency Kits 3). Admission Assessment and Data Collection 4). Clinical Documentation Systems 5). Trilogy Health Services for Admission and Discharges in Matrix</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Review new admissions to ensure the following: 1). physician medication orders were followed as written</p> <p>2). medications were administered in a timely manner</p> <p>3). medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration. 4). If medication is needed before delivery, Emergency Drug Kit (EDK) is utilized 5). If medication is needed and not available in EDK, the back up</p>	

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	<p>6(six) hours as needed for severe pain Tylenol 650 mg every 4 (four) hours as needed for mild pain</p> <p>Review of the Medication Administration Record for September 2015 indicated Resident D did not receive the following medication due to the medication not being available at that time: Dicyclomina HCL 20 mg supper and 9:00 p.m. doses Nexium 40 mg supper dose Restoril 30 mg bedtime dose Zetia 10 mg 9:00 p.m. dose Hydralazine 100 mg supper dose Multivitamin supper dose Bystolic 2.5 mg 9:00 p.m. dose Amitriptyline HCL 50 mg 9:00 p.m. dose Citracal/Vitamin D supper dose</p> <p>Review of the Pharmacy Admitting Face Sheet indicated Resident D's physician medication orders were faxed to the pharmacy on 9/9/15 at 2:16 p.m.</p> <p>Review of the pharmacy delivery sheet, dated 9/10/15, indicated all of Resident D's medication was delivered to the facility and signed for by LPN #3 at 3:15 a.m. No documentation that any medications had been received from the back up pharmacy was available.</p> <p>Review of the EDK (emergency</p>		<p>pharmacy will be utilized 6). If the medication is needed and not available in the EDK and the back up pharmacy delivery is not expected to be timely, the MD will be notified and request a alternative medication order that is stocked in the EDK until the prescribed medications are received from pharmacy. 7). Documentation of MD notification if alternative medication needed is in place 8). Documented Matrix admission arrival time is correct 9). Documented admission assessment time is in place and correct</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>medication kit) list indicated none of Resident D's blood pressure medication was available in the facility.</p> <p>During an interview on 9/30/15 at 3:13 p.m., LPN #2 indicated the following: "Her medications (Resident D) had been ordered from the back up pharmacy [name of pharmacy]. She asked about her medicines and I told her we were waiting to get them from [name of pharmacy]. I even called our pharmacy and they said they were still processing the orders and getting them ordered for the back up pharmacy. It can take up to 4-6 hours to get the medications from the back up pharmacy sometimes. Sometimes it doesn't take that long. I passed it onto the third shift nurse that the medications had not come and she should give them to her as soon as they came in. I don't think her medications were available from our EDK (emergency drug kit)."</p> <p>During an interview on 9/30/15 at 3:55 p.m., LPN #4 indicated the following: "Sometimes there seems to be issues with new admissions getting their medications, especially if they come in late in the evening. We get the orders then verify them with the doctor. Then we fax the orders to the pharmacy. The</p>						

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	<p>pharmacy processes the orders and sends them to the back up pharmacy. We have a contract with a local taxi service. They pick up the medications and deliver them to us. Usually there is good follow up with it, but we have been overwhelmed here lately. If we have multiple admissions, I try to help by taking the vital signs and stuff. [Admission Nurse's name] is strictly an admissions nurse and she doesn't get pulled to do anything else. But sometimes there seems to be some issue with getting pharmacy to get the orders to the back up pharmacy so we can get the medications to the residents "</p> <p>During an interview on 10/1/15 at 11:30 a.m., the Clinical Support Nurse indicated the following: "A note should have been written if there was any difficulty receiving medications from pharmacy and the alternative plan for obtaining medications. If the resident is having pain or significant medical concerns, the physician should be notified and informed if medications are not available and updated on what is available through our EDK (emergency drug kit)."</p> <p>Review of a current policy, dated 2/1/15, titled "Medication Ordering and receiving</p>			

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F 0520 SS=D	<p>from Pharmacy" was provided by the Clinical Support Nurse on 10/1/15 at 2:30. The policy indicated the following: "Policy Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt.</p> <p>Procedures ...3) New medications, EXCEPT for emergency or "stat" medications, are ordered as follows: a. If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and indicate time next dose due. b. Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy delivery...."</p> <p>This Federal tag relates to Complaint IN00182474.</p> <p>3.1-25(a)</p> <p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET</p>			

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Bldg. 00	<p>QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>Based on interview and record review, the facility failed to identify and successfully implement a plan of action to address issues regarding the timely receipt of medications from the facility pharmacy and/or back up pharmacy. This affected 2 of 4 residents reviewed for medication receipt.</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 9/30/15 at 10:22 a.m. Diagnoses for Resident D included, but</p>	F 0520	<p>F 520</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident C and Resident D have been discharged.</p> <p>Identification of other residents having the potential to be</p>	10/31/2015

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	<p>were not limited to, chronic obstructive pulmonary disease, hypertension, total right knee replacement after care, obesity and a history of transient ischemic accidents.</p> <p>Review of Resident D's face sheet indicated Resident D was admitted on 9/9/15 at 11:00 a.m. Review of the Pharmacy Admitting Face Sheet indicated Resident D's physician medication orders were faxed to the pharmacy on 9/9/15 at 2:16 p.m.</p> <p>Review of the physician orders, dated 9/9/15, indicated the following: Zetia (hypercholesterolemia) 10 mg at bedtime Lasix (diuretic) 20 mg daily Glucosamine-Chond (vitamin supplement) daily Hydralazine (anti hypertensive) 100 mg twice daily Mobic (osteoarthritis) 15 mg daily Multivitamin (supplement) daily Bystolic (anti hypertensive) 2.5 mg at bedtime Omega 3 (hypercholesterolemia) 3,000 mg daily Vitamin C (supplement) 1000 mg daily Aspirin (stroke prevention) 81 mg daily Citracal/Vitamin D (supplement) daily Cetirizine HCL (chronic allergies) 10 mg daily</p>		<p>affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all new admissions in the last 24 hours to ensure the medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Quality Assurance Committee on the following guideline: Quality Assessment and Assurance Process</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations will be conducted by the DHS or designee monthly times 6 months to ensure compliance: 1). Review of Quality Assessment and Assurance minutes to ensure the results of the audit and / or observations for medications</p>	

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	<p>Plavix (antiplatelets) 75 mg daily Dicyclomine HCL (osteoarthritis) 20 mg 4 (four) times daily Nexium (antiulcer) 40 mg twice daily K-Dur (potassium supplement) 20 mEq daily Simvastatin (antilipemics) 5 mg at bedtime Restoril (hypnotic) 30 mg at bedtime Calan (anti-hypertensive) 120 mg at bedtime Calan SR (anti-hypertensive) 240 mg daily Ultram (pain medication) 50 mg every 6 (six) hours as needed for moderate pain Ultram (pain medication) 100 mg every 6(six) hours as needed for severe pain Tylenol 650 mg every 4 (four) hours as needed for mild pain</p> <p>Review of the Medication Administration Record for September 2015 indicated Resident D did not receive the following medication due to the medication not being available at that time: Dicyclomina HCL 20 mg supper and 9:00 p.m. doses Nexium 40 mg supper dose Restoril 30 mg bedtime dose Zetia 10 mg 9:00 p.m. dose Hydralazine 100 mg supper dose Multivitamin supper dose Bystolic 2.5 mg 9:00 p.m. dose Amitriptyline HCL 50 mg 9:00 p.m. dose</p>		<p>received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration are reported, reviewed and trended for compliance thru the campus Quality Assurance Committee.</p> <p>The results of the audit and / or observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>	

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	<p>Citracal/Vitamin D supper dose</p> <p>Review of the pharmacy delivery sheet, dated 9/10/15, indicated all of Resident D's medications were delivered to the facility and signed for by LPN #3 at 3:15 a.m. No documentation that any medications had been received from the back up pharmacy was available. Review of the EDK (emergency medication kit) list indicated none of Resident D's blood pressure medications were available in the facility.</p> <p>During an interview on 9/30/15 at 3:13 p.m., LPN #2 indicated: "...It can take up to 4-6 hours to get the medications from the back up pharmacy sometimes. Sometimes it doesn't take that long. I passed it onto the third shift nurse that the medications had not come and she should give them to her as soon as they came in. I don't think her medications were available from our EDK (emergency drug kit)."</p> <p>During an interview on 9/30/15 at 3:55 p.m., LPN #4 indicated: "...Sometimes there seems to be issues with new admissions getting their medications, especially if they come in late in the evening. We get the orders then verify them with the doctor. Then we fax to</p>			

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	<p>orders to the pharmacy. The pharmacy processes the orders and sends them to the back up pharmacy. We have a contract with a local taxi service they pick up the medications and deliver them to us. But sometimes there seems to be some issue with getting pharmacy to get the orders to the back up pharmacy so we can get the medications to the residents "</p> <p>During an interview on 10/1/15 at 11:30 a.m., the Clinical Support Nurse indicated the following: "A note should have been written if there was any difficulty receiving medications from pharmacy and the alternative plan for obtaining medications. If the resident is having pain or significant medical concerns, the physician should be notified and informed if medications are not available and updated on what is available through our EDK (emergency drug kit)." The Clinical Support Nurse indicated there were concerns related to the delivery time of medications from pharmacy. "There seems to be a break in the system and we need to address it."</p> <p>During an interview on 10/1/15 at 12:30 p.m., the Administrator indicated the QAA committee meets monthly. The meeting attendees included, but were not limited to, the Director of Environmental</p>			

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	<p>Services, the Business Office Manager, the Director of Dietary Services, the Director of Nursing Services and the Administrator. The Pharmacy Consultant attends the meetings quarterly and the Medical Director attends the meetings annually but reviews the meeting minutes monthly. The Administrator indicated no concerns regarding the process for medication receipts from the pharmacy and/or back up pharmacy had been previously identified.</p> <p>This Federal tag relates to Complaint IN00182474.</p> <p>3.1-52(b)(2)</p>				