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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 03/26/2014 |
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| NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE | STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904 |
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| F000000 | <p>This visit was for the Investigation of Complaints #IN00145579 & #IN00146206.</p> <p>Complaint #IN00145579 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint #IN00146206 - Substantiated. Federal/state deficiencies related to the allegations are cited at F329, F333 & F501.</p> <p>Survey dates: March 24, 25, & 26, 2014</p> <p>Facility number: 000051 Provider number: 155121 AIM number: 100275490</p> <p>Survey team: Michelle Carter, RN</p> <p>Census bed type: SNF- 18 SNF/NF- 114 Total- 132</p> <p>Census payor type: Medicare- 24 Medicaid- 75 Other- 33 Total- 132</p> | F000000 | We respectfully request a follow up survey as close to 4/9/14 as possible | |

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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| | <p>Sample- 3</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 March 31, 2014.</p> | | | |
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| F000329 SS=D | <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure an adequate review of medication allergies was completed prior to administering an antibiotic that was previously listed as a medication allergy, and failed to provide a clinical rationale for the administration of a second dose of the antibiotic to a resident, with a known allergy, for 1 of 3 residents, in a sample of 3, reviewed for unnecessary medication administration. (Resident C)</p> | F000329 | <p>1. Noted unnecessary medication (Macrobid) for resident C discontinued. Nurse practioner assessed resident on 1/31/14 for adverse reactions, noted resident had allergy, and ordered antibiotic of doxycycline. Nurse giving first dose of Macrobid was counseled and nurse giving second dose of Macrobid is no longer employed with facility. Medication error completed. All residents have the potential to be affected. Clinical records for all other residents reviewed. DNS/designee compared clinical</p> | 04/09/2014 |
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| | <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 3/24/14.</p> <p>Diagnoses for Resident C included, but were not limited to, coronary artery disease, type 2 diabetes, high blood pressure, gastroesophageal reflux disease, cervical spondylosis, rhabdomyolosis, chronic anxiety, chronic airway obstruction, dementia, depression, history of urinary tract infection (UTI), urinary incontinence, and chronic contact dermatitis with unknown origin.</p> <p>The face sheet, dated 3/25/10, for Resident C, indicated the following list of medication allergies: cephalosporins (class of antibiotics) Cipro (antibiotic) nitrofurantoin analogues (class of antibiotic derivatives, includes Macrobid) paroxetine (antidepressant) penicillins (class of antibiotics) quinolones (class of antibiotics) ranitidine (antiulcer) sulfonamides (class of antibiotics)</p> <p>The December 2013 and the January 2014 medication administration records (MARs) and physician order</p> | | <p>records with listed allergies to ensure no additional unnecessary medications were prescribed or administered.3. DNS/designee completed inservicing for licensed staff by 4/8/14 regarding comparing prescribed medications with listed allergies prior to administration and notifying MD immediately with any conflicting orders. DNS/designee will compare all new MD medication orders with clinical record to ensure unnecessary medications are not administered. Pharmacy will also notify facility of any prescribed medications conflicting with listed allergies and will not send to facility.4. To ensure compliance, the DNS/designee will complete the MD order MAR/TAR documentation flow sheet/Continuous Quality Improvement tool weekly x 4, then monthly x 6, then quarterly thereafter. Report to CQI committee, overseen by ED, will occur monthly x 6 months. Compliance will be 100% or action plan will be developed.</p> | | |

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| | <p>recapitulations, were, appropriately, signed by the physician and indicated the following list of medication allergies:</p> <ul style="list-style-type: none"> sulfonamides penicillin's cephalosporins quinolones ranitidine paroxetine nitrofurantoin derivatives <p>Nursing notes, dated 1/26/14, at 7:37 p.m., indicated, "Urine culture came back and MD [physician] on call notified. New order for Atb [antibiotic] for UTI. Resident afebrile this shift. Complains of slight burning upon urination. Continues to be incontinent most of the time. Family and pharm [pharmacy] notified."</p> <p>A physician's telephone order, dated 1/26/14, indicated an order for Macrobid, 100 mg (milligrams), orally, twice a day for 10 days for UTI.</p> <p>Nursing notes, dated 1/26/14, at 10:25 p.m., indicated, "New order for Macrobid, and after Atb given, pharm [pharmacy] notified the writer resident is allergic to this Atb and about every other Atb. No adverse effects yet this shift. MD on call notified. New order to hold Atb for tm [tomorrow] and</p> | | | |
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| | <p>notify primary doctor to see if they want to do IV [intravenous] Atb since resident is allergic to most Atb to get rid of UTI."</p> <p>A physician's order, dated 1/26/14, indicated "Hold Macrobid on 1/27/14, until we hear back from MD."</p> <p>Nursing notes indicated the Macrobid was not administered, per order, on 1/27/14- morning and evening dose, 1/28/14- morning and evening dose, and 1/29/14- morning dose.</p> <p>A nursing note, dated 1/30/14, at 12:06 a.m. (note: this was an overnight shift- the shift began on the evening of 1/29/14 and ended on the morning of 1/30/14), indicated, "Resident taking Macrobid, without any symptoms. Benadryl given for itching. No acute distress noted."</p> <p>On 3/24/14, at 4:30 p.m., during an interview, Unit Manager #2 indicated nurses and pharmacy staff were expected to check medication allergies, especially upon receipt of a new medication order.</p> <p>During an interview with LPN #1, on 3/25/14, at 10:20 a.m., she indicated nurses were to share resident's allergies with the doctor when</p> | | | | | | |

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| | <p>discussing a new order.</p> <p>During an interview on 3/26/14, at 1:45 p.m., the Director of Nursing (DoN) indicated the nurses retrieved the Macrobid (administered on the evening of 1/26/14 and 1/29/14) from the emergency drug kit (EDK). The DoN indicated the pharmacy did not send Macrobid for Resident C. She indicated the dose administered on the evening of 1/26/14 was inadvertent. She indicated the nurse that administered the second dose did not give a reason as to why the second dose was given.</p> <p>Receipts from the EDK confirmed the Macrobid was obtained on 1/26/14 at 7:44 p.m., and 1/29/14 at 9:00 p.m. Pharmacy receipt records, dated January 2014, confirmed there was not a shipment of Macrobid.</p> <p>Nursing notes, dated 1/30/14, at 8:00 a.m., indicated, "..... gave Res [resident] am (sic) [morning] medication and Res started to cough and vomited x 1.Res refused breakfast this am (sic) [morning]."</p> <p>Physician progress notes, dated 1/31/14, indicated Resident C was assessed for adverse reactions and the allergy was noted. Additionally,</p> | | | |
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| | <p>doxycycline was prescribed to treat the UTI.</p> <p>This federal tag relates to Complaint #IN00146206.</p> <p>3.1-48(a)(6)</p> | | | |
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| F000333 SS=D | <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview, the facility failed to ensure the prevention of a medication error, after a medication allergy was identified, for 1 of 3 residents, in a sample of 3, reviewed for significant medication errors. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 3/24/14.</p> <p>Diagnoses for Resident C included, but were not limited to, coronary artery disease, type 2 diabetes, high blood pressure, gastroesophageal reflux disease, cervical spondylosis, rhabdomyolosis, chronic anxiety, chronic airway obstruction, dementia, depression, history of urinary tract infection (UTI), urinary incontinence, and chronic contact dermatitis with unknown origin.</p> <p>The face sheet, dated 3/25/10, for Resident C, indicated the following list of medication allergies: cephalosporins (class of antibiotics) Cipro (antibiotic) nitrofuram analogues (class of</p> | F000333 | <p>1. Medication error associated with administration of Macrobid to resident C. Macrobid was discontinued, nurse practioner assessed resident, and new antibiotic was prescribed. Nurse administering first dose of Macrobid was educated/counseled. Nurse administering second dose of Macrobid no longer is employed by facility. Medication error completed 2. All residents have the potential to be affected. Clinical records for all other residents were reviewed. DNS/designee compared clinical records with listed allergies to ensure no additional unnecessary medications were prescribed or administered. 3. DNS/designee completed inservicing for all licensed staff by 4/8/14 regarding comparing newly prescribed medications with listed allergies prior to administration and notify MD immediately with any conflicting orders as related to allergies. DNS/designee will compare all new orders MD medication orders with clinical record daily to ensure no unnecessary medications are prescribed or administered if there is a listed allergy. Pharmacy will also notify the facility of inability to send medications if</p> | 04/09/2014 | |

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| | <p>antibiotic derivatives, includes Macrobid) paroxetine (antidepressant) penicillins (class of antibiotics) quinolones (class of antibiotics) ranitidine (antiulcer) sulfonamides (class of antibiotics)</p> <p>The December 2013 and the January 2014 medication administration records (MARs) and physician order recapitulations, were, appropriately, signed by the physician and indicated the following list of medication allergies: sulfonamides penicillins cephalosporins quinolones ranitidine paroxetine nitrofurantoin derivatives</p> <p>Nursing notes, dated 1/26/14, at 7:37 p.m., indicated, "Urine culture came back and MD [physician] on call notified. New order for Atb [antibiotic] for UTI. Resident afebrile this shift. Complains of slight burning upon urination. Continues to be incontinent most of the time. Family and pharm [pharmacy] notified."</p> <p>A physician's telephone order, dated 1/26/14, indicated an order for</p> | | <p>there is a listed allergy.4. To ensure compliance, DNS/designee will complete the MD order MAR/TAR Documentation flow sheet/Continuous Quality Improvement tool weekly x 4, then monthly x 6, then quarterly thereafter. Report will be given to CQI committee, overseen by ED, monthly x 6. Compliance will be 100% or an action plan will be developed.</p> | | | | |

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| | <p>Macrobid, 100 mg (milligrams), orally, twice a day, for 10 days, for UTI.</p> <p>Nursing notes, dated 1/26/14, at 10:25 p.m., indicated, "New order for Macrobid, and after Atb given, pharm notified the writer resident is allergic to this Atb and about every other Atb. No adverse effects yet this shift. MD on call notified. New order to hold Atb for tm [tomorrow] and notify primary doctor to see if they want to do IV [intravenous] Atb since resident is allergic to most Atb to get rid of UTI."</p> <p>A physician's order, dated 1/26/14, indicated "Hold Macrobid on 1/27/14, until we hear back from MD."</p> <p>Nursing notes indicated the Macrobid was not administered, per order, on 1/27/14- morning and evening dose, 1/28/14- morning and evening dose, and 1/29/14- morning dose.</p> <p>A nursing note, dated 1/30/14, at 12:06 a.m. (note: this was an overnight shift- the shift began on the evening of 1/29/14 and ended on the morning of 1/30/14), indicated, "Resident taking Macrobid, without any symptoms. Benadryl given for itching. No acute distress noted."</p> | | | |
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| | <p>On 3/24/14, at 4:30 p.m., during an interview, Unit Manager #2 indicated nurses and pharmacy staff were expected to check medication allergies, especially upon receipt of a new medication order.</p> <p>During an interview with LPN #1, on 3/25/14, at 10:20 a.m., she indicated nurses were to share resident's allergies with the doctor when discussing a new order.</p> <p>During an interview on 3/26/14, at 1:45 p.m., the Director of Nursing (DoN) indicated the nurses retrieved the Macrobid (administered on the evening of 1/26/14 and 1/29/14) from the emergency drug kit (EDK). The DoN indicated the pharmacy did not send Macrobid for Resident C. She indicated the dose administered on the evening of 1/26/14 was inadvertent. She indicated the nurse that administered the second dose did not give a reason as to why the second dose was given.</p> <p>Receipts from the EDK confirmed the Macrobid was obtained on 1/26/14 at 7:44 p.m., and 1/29/14 at 9:00 p.m. Pharmacy receipt records, dated January 2014, confirmed there was not a shipment of Macrobid.</p> | | | | | | |

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| | <p>Nursing notes, dated 1/30/14, at 8:00 a.m., indicated, "..... gave Res [resident] am (sic) [morning] medication and Res started to cough and vomited x 1.Res refused breakfast this am (sic) [morning]."</p> <p>Physician progress notes, dated 1/31/14, indicated Resident C was assessed for adverse reactions and the allergy was noted. Additionally, doxycycline was prescribed to treat the UTI.</p> <p>The "2014 Nursing Drug Handbook," page 995, indicated Macrobid had adverse reactions that included, but were not limited to, vomiting, rash and itching.</p> <p>This federal tag relates to Complaint #IN00146206.</p> <p>3.1-48(c)(2)</p> | | | |

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| F000501 SS=D | <p>483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.</p> <p>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.</p> <p>Based on record review and interview, the medical director did not respond in a timely manner and failed to show due diligence in response to a medication error after facility staff gave notification, for 1 of 3 residents, in a sample of 3, reviewed for physician response. (Resident C)</p> <p>Findings include:</p> <p>The clinical record for Resident C was reviewed on 3/24/14.</p> <p>Diagnoses for Resident C included, but were not limited to, coronary artery disease, type 2 diabetes, high blood pressure, gastroesophageal reflux disease, cervical spondylosis, rhabdomyolosis, chronic anxiety, chronic airway obstruction, dementia, depression, history of urinary tract infection (UTI), urinary incontinence, and chronic contact dermatitis with unknown origin.</p> <p>The face sheet, dated 3/25/10, for</p> | | | F000501 | <p>1. Macrobid for res C discontinued. Nurse practioner saw resident 1/31/14. No adverse reactions were evident and antibiotic was changed to Doycycline.2. Current communication with MD in regard to allergies has been reviewed and responses have been timely while conducting allergy audit of all residents.3. Medical Director is in the process of orienting a nurse practionerthat will be dedicated to this facility, to assist in a timely communication process. Orientation for nurse practioner began 4/4/14.All urgent/critical situations will be called to MD immediately. All faxes will be answered within 24 hours or less. MD will be called for any faxes not receiving response in 24 hours or less. 4. DNS/designee will monitor response time to faxes related to ordered medications with noted allergies, in need of clarification daily. MD will be notified by phone if response to fax is not recieved in 24 hours or less. Faxes will be monitored daily x 4 weeks, then 3 x weekly</p> | | 04/09/2014 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 03/26/2014 | |
| NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION ST LAFAYETTE, IN 47904 | | | |
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| | <p>Resident C, indicated the following list of medication allergies: cephalosporins (class of antibiotics) Cipro (antibiotic) nitrofurantoin analogues (class of antibiotic derivatives, includes Macrobid) paroxetine (antidepressant) penicillins (class of antibiotics) quinolones (class of antibiotics) ranitidine (antiulcer) sulfonamides (class of antibiotics)</p> <p>The December 2013 and the January 2014 medication administration records (MARs) and physician order recapitulations, were, appropriately, signed by the physician and indicated the following list of medication allergies: sulfonamides penicillins cephalosporins quinolones ranitidine paroxetine nitrofurantoin derivatives</p> <p>Nursing notes, dated 1/26/14, at 7:37 p.m., indicated, "Urine culture came back and MD [physician] on call notified. New order for Atb [antibiotic] for UTI. Resident afebrile this shift. Complains of slight burning upon urination. Continues to be</p> | | thereafter. Report of compliance will be reviewed in CQI, overseen by ED, monthly x 6 months. | | | | |

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| | <p>incontinent most of the time. Family and pharm [pharmacy] notified."</p> <p>A physician's telephone order, dated 1/26/14, indicated an order for Macrobid, 100 mg (milligrams), orally, twice a day, for 10 days, for UTI. During an interview, on 3/24/13, at 4:30 p.m., with Unit Manager #2, there was not any documentation to support if the physician questioned medication allergies or the condition of the resident.</p> <p>Nursing notes, dated 1/26/14, at 10:25 p.m., indicated, "New order for Macrobid, and after Atb given, pharm notified the writer resident is allergic to this Atb and about every other Atb. No adverse effects yet this shift. MD on call notified. New order to hold Atb for tm [tomorrow] and notify primary doctor to see if they want to do IV [intravenous] Atb since resident is allergic to most Atb to get rid of UTI."</p> <p>A physician's order, dated 1/26/14, indicated "Hold Macrobid on 1/27/14, until we hear back from MD."</p> <p>A fax, dated 1/26/14, addressed to the primary physician for Resident C, which was the medical director, too, indicated, "[Resident C] put on</p> | | | |
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| | <p>Macrobid for UTI. Resident is allergic to this and every other antibiotic. MD on call notified and told us to notify primary [physician].Will put on hold until we hear back."</p> <p>The written communication/response provided by the physician was not legible. Clarification was requested by facility staff. The response, dated 1/28/14, at 4:12 p.m., stated "HAVE MD/NP ADDRESS WHEN THERE". Additionally, a circle with a line through it was drawn directly next to the response.</p> <p>Nursing notes and physician progress notes, dated 1/31/14, indicated the nurse practitioner had a visit with Resident C on 1/31/14. This was 5 days after physician notification and awareness for request for antibiotic.</p> <p>During an interview with Unit Manager #2, on 3/25/14 at 3:45 p.m., she indicated the unit staff were told to communicate with the physician/medical director via fax, only.</p> <p>During an interview with the DoN, on 3/26/14 at 1:45 p.m., she indicated the physician/medical director did not accept phone calls and faxed communication was the only</p> | | | |
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| | <p>acceptable means of communication.</p> <p>The Executive Director indicated a plan was in progress, regarding the need for communication between facility nursing staff and the physician. The plan included scheduling specific days of the week for nurse practitioner visits.</p> <p>This federal tag relates to Complaint #IN00146206.</p> <p>3.1-13(v)(1) 3.1-13(v)(2)</p> | | | |
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