

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/23/2013
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NAME OF PROVIDER OR SUPPLIER TIMBERVIEW HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2350 TAFT ST GARY, IN 46404
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F000000	<p>This visit was for the Investigation of Complaints IN00134339, IN00134414, IN00134583, and IN00134814.</p> <p>Complaint IN00134339- Substantiated. Federal/state deficiencies related to the allegations are cited at F325, F329, F389, and F505.</p> <p>Complaint IN00134414- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00134583- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00134814- Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F325, and F425.</p> <p>Survey dates: August 21-23, 2013</p> <p>Facility number: 008505 Provider number: 155580 AIM number: 200064830</p> <p>Survey team: Janet Adams, RN, TC</p>	F000000		

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>Caitlyn Doyle, RN August 23, 2013 Heather Hite, RN August 23, 2013</p> <p>Census bed type: SNF: 8 SNF/NF: 123 Total: 131</p> <p>Census payor type: Medicare: 8 Medicaid: 112 Other: 11 Total: 131</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on August 29, 2013, by Janelyn Kulik, RN.</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 record review and interview the facility failed to provide the necessary treatment and services to maintain the highest practicable physical well being related to implementing post operative passive motion devices in a timely manner upon admission for 1 of 3 residents reviewed for admission from the hospital in the sample of 8. (Resident #D)</p> <p>Findings include:</p> <p>The closed record for Resident #D was reviewed on 8/22/13 at 11:40 a.m. The resident's diagnoses included, but were not limited to, dementia, adult failure to thrive, high blood pressure, anemia, and cardiac pacemaker. The resident was admitted to the facility on 7/20/13 from the hospital following knee surgery. The resident was sent to the hospital on 8/6/13 and did not return to the facility.</p>	F000309	<p>F309 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>Immediate actions taken for those residents identified: Resident #D- Unable to correct, resident was discharged from facility on 8/11/13. How the facility identified other residents: Audit will be completed of admissions in the last 30 days to identify any other residents receiving CPM treatment. Measures put into place/ System changes: Licensed staff will be educated regarding the use of CPM machine, availability and timely initiation of treatment. Potential admissions will be screened prior to admission to evaluate need for specialized equipment, including CPM machine, to ensure equipment is available and initiated in a timely manner. New admission orders will be reviewed at least 3x/week to ensure specialized equipment</p>	09/22/2013			

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	<p>The 7/2013 Nursing Progress notes were reviewed. An entry on 7/26/13 at 8:48 a.m., indicated the staff contacted the Physician's office to clarify the use of the CPM (device to provide passive motion to flex and extend the knee joint after surgery) to the right knee twice a day at 80 degrees flexion (bending) and increase the flexion by 10 degrees with each session. The entry also indicated the writer was meeting with Physical Therapy to schedule staff education. There was no documentation of the CPM treatment being initiated between 7/26/13 and 7/29/13.</p> <p>Review of the 7/2013 TAR (Treatment Administration Record) indicated the CPM treatment was first initiated on 7/29/13 at 8:00 a.m. and the resident refused the treatment. The treatment was then signed out as completed on 7/29/13 on the evening shift.</p> <p>When interviewed on 8/22/13 at 2:15 p.m., the Director of Nursing indicated the facility did a prescreen assessment at the hospital prior to the resident being accepted for admission and there was no documentation of the need for a CPM machine. The Director of Nursing indicated she was present at a</p>		is available and implemented in a timely manner. The Director of Nursing is responsible for oversight of these audits. How the corrective actions will be monitored: The results of these audits will be reviewed in the monthly Quality Assurance meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/22/13				

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	<p>meeting with the resident's family after the resident's admission and the family had questioned if the resident was to have the machine that moves her knee as she had in the hospital. The Director of Nursing indicated the facility then called the Physician who performed the resident's knee surgery to clarify the above. The Director of Nursing stated the resident was admitted on a Saturday and the meeting occurred either Monday 7/22/13 or Tuesday 7/23/13 and that is when they started inquiring about the machine.</p> <p>When interviewed on 8/22/13 at 3:15 p.m., the Unit Manager indicated she and another Nurse were inserviced on the use of the CPM machine when it was delivered to the facility on 7/26/13. The Unit Manager indicated they began inservicing other staff member when they came to work. The Unit Manager indicated the TAR was not signed out as the machine being in place until 7/29/13.</p> <p>This federal tag relates to Complaint IN00134814.</p> <p>3.1-37(a)</p>				

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the registered Dietician's recommendations for changes in tube feeding infusion rates were addressed in a timely manner for 1 of 3 residents reviewed for enteral tube feedings in the sample of 8. (Resident # G)</p> <p>The facility also failed to follow their policy related to notifying the Registered Dietitian to assesses the nutritional needs for residents admitted with PEG (Percutaneous Endoscopic Gastrostomy) for 1 of 3 residents reviewed with PEG tubes in the sample of 8. (Resident #C)</p> <p>The facility also failed to follow their policy related to obtaining re-weights in a timely manner for 1 of 3 reviewed for recent admissions to the facility. (Resident #D)</p>	F000325	<p>F325 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care.</p> <p>Immediate actions taken for those residents identified: Resident #G- Physician was notified of dietician recommendation on 8/22/13 and orders were obtained. Resident #D- Unable to correct, resident was discharged from facility on 8/11/13. Resident #C- Unable to correct, resident was discharged from facility on 7/25/13. How the facility identified other residents: Dietician recommendations received in the last 30 days were reviewed to ensure physicians were notified and orders received. Physicians were notified on 8/22/13 and orders obtained for Dietician recommendations from 7/22/13. Admissions and readmissions in the last 30 days</p>	09/22/2013			

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	<p>Findings include:</p> <p>1. On 8/21/13 at 10:35 a.m., Resident #G was observed in bed. The resident was receiving Jevity 1.2 enteral feeding at 80 cc's (cubic centimeters) via a pump through a PEG tube. On 8/21/13 at 1:00 p.m., the resident was sitting in a Broda (specialty chair). The resident was receiving Jevity 1.2 enteral tube feeding at 80 cc's per hour via an infusion pump at 80 cc's an hour.</p> <p>On 8/22/13 at 7:50 a.m. and 10:30 a.m., Resident #G was observed in bed. The resident was receiving Jevity 1.2 enteral tube feeding at 80 cc's per hour via an infusion pump at 80 cc's an hour.</p> <p>The record for Resident #G was reviewed on 8/22/13 at 12:00 p.m. The resident's diagnoses included, but were not limited to, adult failure to thrive, gastrostomy tube, Alzheimer's disease, and contractures.</p> <p>Review of the current Physician orders indicated there was an order for the resident to receive Jevity 1.2 tube feeding at 80 cc's an hours for 18 hours a day. The order also indicated the tube feeding was to be on at 6:00 a.m. and off at midnight</p>		<p>will be reviewed to ensure weights and re-weights were obtained timely, dietician notified of residents receiving tube feeding and dietician assessment and recommendations were completed as indicated. Measures put into place/ System changes: Registered Dietician (RD) , Dietary Manager and NAR committee were in-serviced regarding timely notification and follow-up of RD recommendations, RD notification of admissions/ re-admissions receiving tube feeding, and policy for obtaining weights and re-weights. Licensed staff will be in-serviced regarding RD notification of admissions/re-admissions receiving tube feeding within 24 hours of admission. Licensed staff and CNA's will be in-serviced on policy for obtaining weights and re-weights. Admissions/re-admissions will be reviewed at least 3x/week to ensure RD is notified timely of residents receiving tube feeding. RD recommendations will be reviewed weekly in Nutrition at Risk (NAR) meeting to ensure recommendations are completed in a timely manner. Admissions/re-admissions will be reviewed weekly in NAR meeting to ensure weights and re-weights are obtained timely and RD assessments are completed as indicated. The Dietary Manager is responsible for oversight of</p>		

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	<p>every day. The order was originally written on 1/24/13. There were no Physician orders written to change the rate of the tube feeding infusion in July 2013 or August 2013.</p> <p>A Weight Change Dietary Progress note was completed by the RD (Registered Dietitian) on 7/21/13. The note indicated the resident's weights were as follows: 1/11/13 - 138.9 pounds 4/25/13 - 147.2 pounds 7/05/13 - 161.6 pounds The RD recommendations were to decrease the tube rate to 70 cc's per hours for 18 hours a day.</p> <p>Review of the 7/13 and 8/13 Nursing Progress notes indicated there was no documentation of the above RD recommendations being acted upon.</p> <p>When interviewed on 8/22/13 at 3:30 p.m., the Nurse Consultant indicated the facility protocol is for the RD to a leave a copy of her recommendations with the Dietary Manager and the Nursing Unit Managers. The Nurse Consultant indicated they were unable to locate the 7/21/13 RD's recommendation for Resident #G at this time.</p> <p>When interviewed on 8/23/13 at 8:45</p>		<p>these audits. How the corrective actions will be monitored: The results of these audits will be reviewed in the monthly Quality Assurance meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/22/13</p>		

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	<p>a.m., the Director of Nursing indicated the 7/21/13 RD recommendations had been located. The Director of Nursing indicated the 7/21/13 recommendation to decrease the resident's tube feeding rate was not addressed prior to 8/22/13. The Director of Nursing indicated the RD recommendations should have been addressed when they were received.</p> <p>2. The closed record for Resident #D was reviewed on 8/22/13 at 11:40 a.m. The resident's diagnoses included, but were not limited to, dementia, adult failure to thrive, high blood pressure, anemia, and cardiac pacemaker. The resident was admitted to the facility on 7/20/13 from the hospital following knee surgery. The resident was sent to the hospital on 8/6/13 and did not return to the facility.</p> <p>The resident's weight records were reviewed. There were only two weights recorded for 7/2013. The recorded weights were as follows: 7/20/13 167.3 pounds (per electronic record) 7/31/13 151.8 pounds (per a paper copy of the Dietary Managers weight records) 8/6/13 151.8 pounds (per electronic record)</p>				

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	<p>There was no re-weight recorded between 7/31/13 and 8/6/13.</p> <p>The policy titled "Resident Weight Evaluation" was reviewed on 8/21/13 at 3:24 p.m. The policy had a revision date of 6/12. The policy was received from the Nurse Consultant and identified as current. The policy indicated residents with a 5 pound weight change were to be re-weighed within 24 hours.</p> <p>When interviewed on 8/23/13 at 8:24 a.m., the Director of Nursing indicated the residents's weights were as recorded and a re-weight should have been done after the 7/31/13 weight.</p> <p>3. The closed record for Resident #C was reviewed on 8/22/13 at 10:50 a.m. The resident's diagnose included, but were not limited to, chronic kidney disease, malignant neoplasm of the prostate, chronic airway obstruction, urethral strictures, convulsions, anemia, contractures, and esophageal reflux. The resident was admitted to the facility on 4/26/13. The resident was sent to the hospital on 5/14/13 and readmitted to the facility on 6/4/13. The resident was sent to the hospital on 6/13/13 and readmitted to the facility on 6/28/13. The resident was sent to the</p>						

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	<p>hospital on 7/21/13 and did not return to the facility.</p> <p>A 5/3/13 Dietary-Nutritional Risk Assessment note was completed by the Registered Dietitian. The note indicated the resident's mini nutrition score was (6). This score indicated the resident was malnourished, possibly due to decreased intake, limited mobility, and a recent hospitalization. The note also indicated the resident was currently receiving a mechanical soft diet. There were no further Dietary Progress Notes in May 2013.</p> <p>Review of the 6/2013 Nursing Progress Notes indicated the first entry was made on 6/4/13 at 4:40 p.m. This entry indicated the resident returned from the hospital and was noted to have a PEG tube in place to the abdomen and the PEG tube site was clean and dry. The entry also indicated the resident was receiving Jevity 1.2 tube feeding at 70 ml's (milliliters) an hour. Review of the Nursing Progress Notes between 6/4/13 and 6/10/13 indicated there was no documentation of the Registered Dietitian being notified of the resident's 6/4/13 re-admission to the facility with a newly inserted PEG tube for feedings.</p>			

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	<p>The 6/2013 Dietary Progress Notes were reviewed. The first entry was made on 6/7/13. This entry was made by the Dietary Manager. This entry indicated the resident was receiving nothing by mouth, was a tube feeder, weight 151 pounds, and BMI was in the normal range. The next entry was made on 6/10/13 by the Dietary Manager. This entry indicated the resident was a tube feeder and his weight was constant at 151 pounds. There were no progress notes completed by the Registered Dietitian between 6/4/13 and 6/10/13.</p> <p>The facility policy titled "Tube Feeding Orders" was reviewed on 8/21/13 at 3:40 p.m. The policy was provided by the Nurse Consultant and identified as current. The policy indicated the Dietary Manager or Charge Nurse were to notify the Registered Dietitian within 24 hours of admission or when a tube feeding order is changed.</p> <p>When interviewed on 8/22/13 at 3:45 p.m., the Nurse Consultant indicated the facility policy indicated the Registered Dietitian was to be notified of resident's admitted with feeding tubes within 24 hours.</p>			

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	This federal tag relates to Complaints IN00134339 and IN00134814. 3.1-46(a)(1)				

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F000329 SS=G	<p>483.25(I) 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 the resident's drug regime remained free of unnecessary drugs related to lack of monitoring PT/INR (Prothrombin/International Normalized Ratio) laboratory test levels for the use of blood thinners in a timely manner for 1 of 3 residents reviewed for change in condition in the sample of 8. This resulted in a Critical laboratory level requiring the administration of Vitamin K to</p>	F000329	F329 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified: Resident #C- Unable to correct, resident was discharged from facility on 7/25/13. How the facility identified other residents: PT/INR results in the last 30 days of all residents receiving	09/22/2013	

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	<p>reverse the effects of the blood thinning medication. (Resident #C)</p> <p>Findings include:</p> <p>The closed record for Resident #C was reviewed on 8/22/13 at 10:50 a.m. The resident's diagnose included, but were not limited to, chronic kidney disease, malignant neoplasm of the prostate, chronic airway obstruction, urethral strictures, convulsions, anemia, contractures, and esophageal reflux. The resident was admitted to the facility on 4/26/13.</p> <p>Review of the 7/2013 Medication Administration Record indicated there were orders for the resident to receive Coumadin (a blood thinner) 5 milligrams via the gastrostomy tube (a tube placed through the abdomen into the stomach used to provide feeding and medications through) every evening for anticoagulation (thinning the blood to prevent blood clots). The medication was initially ordered on 6/29/13. The Coumadin 5 milligrams was signed out as given at 4:00 p.m. daily 7/1/13 through 7/10/13.</p> <p>The 7/3/13 PT/INR laboratory test results were as follows:</p>		<p>Coumadin will be reviewed to identify any other residents affected. Physicians will be notified of any concerns. Measures put into place/ System changes: Licensed staff will be in-serviced regarding procedure for obtaining PT/INR results and prompt physician notification prior to administering Coumadin. PT/INR results will be reviewed 3x/week on lab draw days to ensure results are received and results communicated to physicians in a prompt manner. The Director of Nursing is responsible for oversight of these audits. How the corrective actions will be monitored: The results of these audits will be reviewed in the monthly Quality Assurance meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/22/13</p>		

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	<p>7/03/13 PT-19.2 (Low) INR-1.82 (Low)</p> <p>The 7/10/13 PT/INR laboratory test results were as follow: PT- 46.1 (High) INR- 4.10 (High) The 7/10/13 laboratory test result report indicated the specimen was collected by the Laboratory on 7/10/13 at 6:57 a.m. and the results were faxed to the facility on 7/10/13 at 11:46 a.m. There was writing on the bottom of the form which noted "hold coumadin today & tomorrow, repeat PT/INR on Saturday." There was no date, time, or initial/signature next the above writing.</p> <p>The 7/13/13 laboratory test results indicated the PT/INR level were as follows: PT- 62.5 (High) INR- 5.35 (Critical) The 7/13/13 Physician orders were reviewed. There was a Physician's order written on 7/13/13 for the resident to receive Vitamin K 5 milligrams three times a day via the gastrostomy tube for (2) days. The 7/13 Medication Administration Record indicated the initial dose of the Vitamin K was administered on</p>						

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	<p>7/13/13 at 4:00 p.m.</p> <p>The 7/15/13 laboratory test results indicated the PT/INR level were as follows: PT-18.1 (Low) INR- 1.72 (Low)</p> <p>Review of the 7/2013 Nursing Progress Noted were reviewed. There was no documentation of attempts to notify the Physician of the 7/10/13 PT/INR laboratory test results. An entry made on 7/11/13 at 4:39 p.m., indicated the Physician and Responsible Party were notified of the PT/INR results of PT-46.1 and INR -4.10, the resident's Coumadin was to be held today and tomorrow, and a PT/INR test was to drawn on Saturday July 13, 2013.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated Coumadin was classified as an anticoagulant drug which could cause major or fatal bleeding. Bleeding was more likely with higher INR (international Normalized Ratio) levels and INR levels should be monitored regularly.</p> <p>The facility policy titled "Physician/Family/Responsible Party Notification For Change in Condition"</p>						

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	<p>was reviewed on 8/22/13 at 10:30 a.m. The policy had a revised date of 1/2012. The Director of Nursing provided the policy and identified the policy as current. The policy indicated medical care problems were to be communicated to the attending Physician in a timely, efficient, and effective manner. The policy also indicated the Physician was to be notified of abnormal laboratory test results</p> <p>When interviewed on 8/22/13 at 10:28 a.m., the Nurse Consultant indicated the results of the high PT/INR levels above were faxed to the facility on 7/10/13. The Nurse Consultant indicated they were not called the Physician until 7/11/13 and Coumadin was not held until 7/11/13.</p> <p>When interviewed on 8/22/13 at 10:45 a.m., the Nursing Unit Manager indicated the 7/10/13 PT/INR lab results were not followed through on 7/10/13. The Unit Manager indicated if the Physician were called when the results came in 7/10/13 the 4:00 p.m. dose of Coumadin could have been held that day.</p> <p>This federal tag relates to Complaint IN00134339.</p>						

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F000389 SS=D	<p>483.40(d) PHYSICIAN FOR EMERGENCY CARE, AVAILABLE 24HR The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency. Based on record review and interview the facility failed to ensure Physician services were available related to lack of attempts to notify an alternative Physician or the facility Medical Director when the attending Physician's calls were not returned for 1 of 3 residents reviewed for admission to the facility in the sample of 8. (Resident #C)</p> <p>Findings include:</p> <p>The closed record for Resident #C was reviewed on 8/22/13 at 10:50 a.m. The resident's diagnose included, but were not limited to, chronic kidney disease, malignant neoplasm of the prostate, chronic airway obstruction, urethral strictures, convulsions, anemia, contractures, and esophageal reflux. The resident was admitted to the facility on 4/26/13.</p> <p>The 4/2013 Nursing Progress Notes were reviewed. An entry made on 4/26/13 at 2:45 p.m. indicated the resident arrived at the facility via</p>	F000389	<p>F389 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified: Resident #C- Unable to correct, resident was discharged from facility on 7/25/13. How the facility identified other residents: Admissions/re-admissions in the last 30 days will be reviewed to ensure physician was notified and responded in a timely manner to verify orders. Measures put into place/ System changes: Licensed staff will re in-serviced regarding physician notification and procedure for notifying alternate physician or Medical Director if primary physician does not respond in a timely manner. Admissions/ re-admissions will be reviewed at least 3x/week to ensure physician or alternate physician are notified in a timely manner to verify orders. The Director of Nursing will be responsible for oversight of these audits. How the corrective actions will be monitored: The results of these audits will be</p>	09/22/2013	

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	<p>ambulance and was transferred into bed. The entry also indicated the resident had no signs of distress or discomfort and report was passed on to the oncoming shift. There was no documentation of attempts to notify the Physician of the resident's admission in this entry.</p> <p>The next entry was made on 4/26/13 at 5:15 p.m. This entry indicated the resident's Physician was paged to be made aware of the resident's arrival to the facility to obtain orders and staff were still awaiting a return call from the Physician.</p> <p>The next entry was made on 4/26/13 at 7:40 p.m. This entry indicated the Physician was called three times and no answer or call back was received.</p> <p>The next entry was made on 4/26/13 at 8:03 p.m. There was no documentation of attempts to notify a Physician noted in this entry.</p> <p>The next entry was made on 4/26/13 at 10:23 p.m. This entry indicated the Physician was paged again and no call back was received. The oncoming Nurse was made aware.</p> <p>The next entries were made on 4/27/13 at 5:39 a.m. and 2:25 p.m.</p>		<p>reviewed in the monthly Quality Assurance meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/22/13</p>		

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	<p>There was no documentation of any attempts to call a Physician for admission orders in either of these entries.</p> <p>The next entry was made on 4/27/13 at 4:53 p.m. This entry indicated the Nurse spoke with the Physician regarding the resident being admitted to the facility and the need for the medications to be verified. Orders were received to continue all the medications the resident had been receiving in the hospital.</p> <p>The April 2013 MAR (Medication Administration Record) was reviewed. The MAR indicated resident's medications were first administered as follows: Flagyl (an antibiotic) 500 milligrams one every 12 hours- 4/29/13 at 8:00 p.m. Kepra (a medication to control seizures) 500 milligrams twice a day- initial dose given 4/28/13 at 8:00 a.m. Flomax (a medication to increase urine flow) 0.4 milligrams daily- initial dose given 4/28/13 at 8:00 a.m. Folic Acid (a mineral supplement) 400 micrograms daily- initial dose given 4/28/13 at 8:00 a.m. Loratadine (a medication for allergies) 10 milligrams daily- initial dose give 4/28/13 at 8:00 a.m.</p>						

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	<p>Megestrol (a medication to increase appetite) 20 milligrams daily- initial dose given 4/28/13 at 8:00 a.m. Mulitex vitamin -initial dose given 4/28/13 at 8:00 a.m. Protonix (a medication to decrease stomach acid) 40 milligrams daily- initial dose given 4/28/13 at 8:00 a.m.</p> <p>The facility policy titled "Physician/Family/Responsible Party Notification for Changes in Condition" was reviewed on 8/22/13 at 10:30 a.m. The policy had a revised date of 1/2012. The Director of Nursing indicated the policy was current. The policy indicated medical problems are to be communicated to the attending Physician in a timely, efficient, and effective manner. The policy did not address alternate measures to be followed when Physician calls were not returned.</p> <p>When interviewed on 8/23/13 at 9:30 a.m., the Director of Nursing indicated the Nursing staff should have attempted to call a covering or associate Physician when the attending Physician did not return calls. The Director of Nursing indicated if that Physician was not available the Medical Director should have been contacted to obtain orders. The Director of Nursing indicated the</p>						

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	<p>above policy was the policy used for notification.</p> <p>This federal tag relates to Complaint IN00134339.</p> <p>3.1-22(e)</p>				

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F000425 SS=D	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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. Based on record review and interview, the facility failed to ensure pharmaceutical services were available to ensure medications were provided to residents in timely manner upon admission to the facility for 1 of 3 residents reviewed for new admissions in the sample of 8. (Resident #H)</p> <p>Findings include:</p> <p>1. The record for Resident #H was reviewed on 8/22/13 at 9:00 a.m. The resident was admitted to the facility on 5/29/13 at 6:00 p.m. The</p>	F000425	F425 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified: Resident #H- Medication error completed and physician notified of delay in initiating medications. How the facility identified other residents: Admissions/ re-admissions in the last 30 days will be reviewed to identify any other residents affected and physicians will be notified as	09/22/2013	

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	<p>resident's diagnoses included, but were not limited to, congestive heart failure, cellulitis of the left foot, diabetes mellitus, anemia, and hypothyroidism.</p> <p>Review of the 5/2013 Medication Administration Record indicated there were admission Physician orders for the resident to receive Digoxin (a cardiac medication) 0.25 milligrams once a day, Klor- Con 20 milliequivalent (a potassium supplement), Spironolactone (a cardiac medication) 12.5 milligrams one time a day, Cephalexin(an antibiotic) a 500 milligrams one tablet two times a day for cellulitis, Carvedilol (a cardiac medication) 6.25 milligrams two times a day for high blood pressure, and Lasix (a diuretic) 40 milligrams two times a day.</p> <p>The 5/2013 Medication Administration Record indicated the initial dose of the above medications were first administered as follows: Digoxin 0.25 milligrams- first administered on 5/31/3 at 8:00 a.m. Klor-Con 20 milliequivalent- first administered on 5/31/3 at 8:00 a.m. Spironolactone 12.5 milligrams first administered on 5/31/13 at 5/31/13 at 8:00 a.m. Cephalexin 500 milligrams twice a</p>		<p>indicated. Measures put into place/ System changes: Pharmacy was notified of concerns with timely delivery of medications.Pharmacy will send a short-term supply of medications not available in EDK from the back-up pharmacy for new admissions to be used until supply is delivered to facility. Licensed staff will be in-serviced regarding timely pharmacy notification of admission medication orders,order cut-off times, use of EDK, and short-term supply of medications to be sent from back-up pharmacy to ensure timely initiation of medications. New admissions will be reviewed at least 3x/week to ensure medications were received and initiated timely. The Director of Nursing is responsible for oversight of these audits. How the corrective actions will be monitored: The results of these audits will be reviewed in the monthly Quality Assurance meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/22/13</p>		

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	<p>day- first administered on 5/30/13 at 4:00 p.m. Carvedilol 6.25 milligrams- first administered on 5/30/13 at 4:00 p.m. Lasix 40 milligrams- first administered on 5/30/13 at 4:00 p.m.</p> <p>When interviewed on 8/22/13 at 1:40 p.m., LPN #1 indicated when resident's are admitted the Physician orders for medications were to be faxed to the pharmacy. The LPN indicated if the orders were not sent in by the cut off time of 5:00 p.m., the medications were not delivered on the night pharmacy delivery. The LPN indicated the Pharmacy delivery is in the evening sometimes towards the end of the Evening shift or the beginning of the night shift daily. LPN #1 also indicated if the medications do not come on the evening delivery they may not come until the following late evening unless they are ordered Stat. The LPN also indicated there were some medications that are kept in the EDK (Emergency Drug Kit) which may be used if they are available.</p> <p>When interviewed on 8/22/13 at 3:15 p.m. the Director of Nursing indicated the facility receives medications daily from the Pharmacy in the evenings if they are faxed to the Pharmacy by</p>				

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	<p>the cut off time of 4-5:00 p.m. The Director of Nursing indicated medications could be ordered Stat by Nursing staff.</p> <p>This federal tag relates to Complaint IN00134814.</p> <p>3.1-25(a) 3.1-25(g)(2)</p>				

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F000505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure the Physician was notified of high PT/INR (a blood test to test for clotting time) laboratory test results in a timely manner for 1 of 3 residents reviewed with recent hospitalizations in the sample of 8. This resulted in a Critical PT/INR level as the resident's Coumadin (a medication to thin the blood) continued to be administered due to the delay in notifying the Physician. (Resident #C)</p> <p>Findings include:</p> <p>The closed record for Resident #C was reviewed on 8/21/13 at 10:50 a.m. The resident's diagnoses included, but were not limited to, chronic kidney disease, malignant neoplasm of the prostate, chronic airway obstruction, urethral strictures, convulsions, anemia, contractures, and esophageal reflux. The resident was admitted to the facility on 4/26/13.</p> <p>The 7/2013 laboratory test results were reviewed. The results of the</p>	F000505	<p>F505 The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. Immediate actions taken for those residents identified: Resident #C- Unable to correct, resident was discharged from facility on 7/25/13. How the facility identified other residents: PT/INR results in the last 30 days of all residents receiving Coumadin will be reviewed to identify any other residents affected. Physicians will be notified of any concerns. Measures put into place/ System changes: Licensed staff will be in-serviced regarding procedure for obtaining PT/INR results and prompt physician notification prior to administering Coumadin. PT/INR results will be reviewed 3x/week on lab draw days to ensure results are received and results communicated to physicians in a prompt manner. The Director of Nursing is responsible for oversight of these audits. How the corrective actions will be monitored: The results of these audits will be reviewed in the monthly Quality</p>	09/22/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155580		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/23/2013	
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	<p>7/2013 PT/INR (Prothrombin/ (International Normalized Ratio) levels and tests were as follows:</p> <p>07/10/13 PT- 46.1 (High) INR- 4.10 (High) The results report indicated the specimen was collected by the Laboratory on 7/10/13 at 6:57 a.m. and the results were faxed to the facility on 7/10/13 at 11:46 a.m. There was writing on the bottom of the form which noted "hold coumadin today & tomorrow, repeat PT/INR on Saturday." There was no date, time, or initial/signature next the above writing.</p> <p>07/13/13 PT- 62.5 (High) INR- 5.35 (Critical)</p> <p>The 7/10/13 Nursing Progress Notes were reviewed. There was no documentation of attempts to notify the Physician of the 7/10/13 PT/INR laboratory test results. An entry made on 7/11/13 at 4:39 p.m., indicated the Physician and Responsible Party were notified of the PT/INR results of PT-46.1 and INR -4.10, the resident's Coumadin was to be held today and tomorrow, and a</p>		Assurance meeting monthly x3 months, then quarterly x1 for a total of 6 months. 5) Date of compliance: 9/22/13				

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	<p>PT/INR test was to drawn on Saturday July 13, 2013.</p> <p>When interviewed on 8/22/13 at 10:28 a.m., the Nurse Consultant indicated the results of the high PT/INR levels above were faxed to the facility on 7/10/13 at 11:46 a.m. The Nurse Consultant indicated they were not called the Physician until 7/11/13 and Coumadin was not held until 7/11/13.</p> <p>When interviewed on 8/22/13 at 10:45 a.m., the Nursing Unit Manager indicated the 7/10/13 PT/INR lab results were not followed through on 7/10/13. The Unit Manager indicated if the Physician were called when the results came in 7/20/13 the 4:00 p.m. dose of Coumadin could have been held that day.</p> <p>This federal tag relates to Complaint IN00134339.</p> <p>3.1-49(f)(2)</p>				