

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155506	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  11/21/2011
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NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN46635
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F0000	<p>This visit was for the Investigation of Complaints IN00098990 and IN00100117.</p> <p>Complaint IN00098990 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00100117 - Substantiated. Federal/state deficiencies related to the allegations are cited at F 282 and F 425.</p> <p>Survey dates: November 19, 20, &amp; 21, 2011</p> <p>Facility number: 001201 Provider number: 155506 AIM number: 100380860</p> <p>Survey team: Vicki Manuwal, RN-TC Bobbie Costigan, RN</p> <p>Census bed type: SNF/NF 99 Total 99</p> <p>Census payor type: Medicare 30 Medicaid 55 Other 14 Total 99</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F0282 SS=E	<p>Sample: 6 Supplemental sample: 1</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 11/29/11 by Suzanne Williams, RN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, interview, and record review, the facility failed to ensure physician orders and plan of care were followed related to medication orders for 4 of 6 residents (Resident # B, # D, # E, # G) in a sample of 6 and 1 of 1 resident (Resident # H) in a supplemental sample of 1 reviewed for physician orders and to ensure a pain assessment was completed as care planned, for 2 of 6 residents (Resident # E, # G) reviewed for care plans in a sample of 6 and failed to complete vital signs as ordered by the physician for 1 of 6 residents (Resident # D) reviewed for physician orders in a sample of 6.</p> <p>Findings include:</p> <p>1. The clinical record for Resident # G, reviewed on 11/19/11 at 6:40 P.M., indicated diagnoses of, but not limited to: chronic anxiety, chronic renal</p>	F0282	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submissin of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>F 282</p> <p>It is the intent of this Facility to have the services provided or arranged are provided by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective action will be done by the Facility? Resident G, E, and D have been assessed; no adverse reaction. Residents B and H no longer reside at Facility.</p> <p>How will the Facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</p>	12/20/2011	

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	<p>insufficiency, and femur fracture.</p> <p>Review of a Physician's Order, dated 9/29/11, indicated, "...Alprazolam (anti anxiety medication) 0.25 mg (milligrams) Give 1 tablet by mouth twice daily..."</p> <p>Review of another Physician's Order, dated 10/27/11, indicated, "...Aldactone (diuretic) 50 mg 1 by mouth daily..."</p> <p>Review of the November 2011, MAR (Medication Administration Record) indicated Resident # G did not receive her scheduled Alprazolam on 11/14/11 PB (prior to bed), 11/15/11 PB, 11/16/11 UR (upon rising) &amp; PB, and 11/17/11 UR.</p> <p>The November 2011, MAR further indicated, "...11/14/11 Xanax (Alprazolam) 0.25 pharm (pharmacy) notified. Await Rx (prescription) authorization...11/15/11 Xanax 0.25 physician &amp; pharm notified. Awaiting Rx auth...11/16/11 Xanax 0.25 pharm notified. Awaiting Rx auth..."</p> <p>Further review of the November 2011, MAR indicated Resident # G did not receive her Aldactone on 11/3, 11/4, 11/5, 11/6, 11/9, 11/11, 11/12, 11/13, 11/14, 11/15, 11/17, 11/18, and 11/19/11.</p> <p>Review of Resident # G's care plan dated</p>		<p>Audits of Medication Administration Records completed. No other residents were identified.</p> <p>What measures will be put into place to ensure this practice does not recur?The Facility reviewed its policy and found it to be sufficient.</p> <p>Staff re-educated on protocol for if medications not available, administration of medication per Doctor's orders, and following residents' plan of care.</p> <p>How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? Director of Nursing or designee will conduct audits of Medication Administration Records 5 times weekly. Audits will be submitted to Mission Driven Quality Assurance Committee monthly times 6. Then, after 3 months of no deficiency with audits, committee will determine whether further monitoring is necessary or if the monitoring can be stopped.</p>		

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	<p>9/30/11, indicated, "...anxiety and use of an antianxiety...Administer to me my medication(s) as ordered....Pain Management as I need or have ordered...</p> <p>During interview with LPN # 1 on 11/19/11 at 8:05 P.M., she indicated Resident # G did not receive her scheduled Xanax on 11/14, 11/15, 11/16, when she worked because it wasn't available in the facility. She further indicated the MAR indicated the Aldactone was not given on the above dates but it should have been.</p> <p>Interview with the DON (Director of Nursing) on 11/20/11 at 3:45 P.M., indicated she was not going to make an excuse for the resident not receiving her Aldactone because it should have been given. She further indicated the error would have warranted a medication error report if they would have been aware of the error.</p> <p>Review of the "Controlled Drug Record" dated 10/1/11 through 11/18/11, for Hydrocodone/APAP (pain medication) 5/325 mg indicated Resident # G received the following 14 doses of Hydrocodone which lacked documentation of an assessment on the "Pain Management Flow Sheet": 10/5/11 6:15 P.M., 10/12/11 9:00 A.M., 10/15/11 7:00 P.M.,</p>				

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	<p>10/18/11 8:15 A.M., 10/18/11 10:00 P.M., 10/23/11 9:00 P.M., 10/25/11 5:00 P.M., 10/28/11 8:15 A.M., 10/28/11 5:00 P.M., 11/1/11 7:30 P.M., 11/8/11 8:30 P.M., 11/16/11 8:30 A.M., 11/16/11 5:00 P.M., 11/17/11 9:00 P.M.</p> <p>Review of Resident # G's care plan, dated 9/30/11, indicated, "...Pain...Assess resident pain by using the pain assessment tool or scale and note response to pain.</p> <p>During interview with LPN # 3 on 11/19/11 at 8:27 P.M., she indicated it is policy to complete the flow sheet for pain assessment when giving pain medications.</p> <p>Interview with the Administrator on 11/20/11 at 3:25 P.M., she indicated it is policy to complete the pain assessment when giving pain medications.</p> <p>During interview with RN # 2 on 11/21/11 at 12:05 P.M., she indicated there were multiple times that Resident # G received pain medications which lacked documentation of a pain assessment.</p> <p>2. The clinical record for Resident # E, reviewed on 11/19/11 at 10:05 P.M., indicated diagnoses of, but not limited to: knee infection, heart disease, and osteoarthritis.</p>				

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	<p>Review of a Physician's Order, dated 11/11/11, indicated, "...Vit (vitamin) C po (orally) QD (every day) 1000 mg supplement...Cyanocobalamin (Vitamin B 12) 1000 mcg po QD supplement..."</p> <p>Review of the November 2011, MAR indicated Resident # E did not receive his scheduled Vitamin C on 11/13/11, 11/14/11, and 11/15/11</p> <p>The November 2011, MAR further indicated, "...11/17/11 Vitamin C 1000 mg, med (medication) not available, pharmacy, MD aware missed dose..."</p> <p>Further review of the November 2011, MAR indicated Resident # E did not receive his Vitamin B 12 on 11/14, 11/15, 11/16, and 11/17/11.</p> <p>The November 2011, MAR further indicated, "...11/17/11 Vitamin B 12, med not available, pharm call, MD aware missed dose..."</p> <p>Review of Resident # E's care plan dated 11/11/11, indicated, "...Infection...Administer meds as ordered..."</p> <p>During interview with the DON on 11/21/11 at 12:10 P.M., she indicated the facility had switched pharmacy providers</p>			

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	<p>from an Indiana provider to a Michigan provider which resulted in having to re-script the entire resident population.</p> <p>Review of the "Controlled Drug Record" dated 11/12/11 through 11/21/11, for Hydrocodone/APAP (pain medication) 5/325 mg indicated Resident # E received the following dose of Hydrocodone which lacked documentation of an assessment on the "Pain Management Flow Sheet": 11/12/11 7:30 P.M.</p> <p>Review of Resident # E's care plan dated 11/11/11, indicated, "...Pain...Assess resident pain by using the pain assessment tool or scale and note response to pain..."</p> <p>During interview with LPN # 3 on 11/19/11 at 8:27 P.M., she indicated it is policy to complete the flow sheet for pain assessment when giving pain medications.</p> <p>Interview with the Administrator on 11/20/11 at 3:25 P.M., she indicated it is policy to complete the pain assessment when giving pain medications.</p> <p>3. The clinical record for Resident # D, reviewed on 11/20/11 at 10:55 A.M., indicated diagnoses of, but not limited to: hypertension, urinary tract infection, and diabetes mellitus.</p>				

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	<p>A Physician's Order, dated 9/30/11, indicated, "...Cipro (antibiotic) 500 mg po daily x 7 days..."</p> <p>Review of the October 2011, MAR indicated Resident # D received doses of Cipro on 10/1/11, 10/2/11, 10/3/11, 10/4/11, 10/5/11, and 10/6/11.</p> <p>During interview with the Administrator on 11/21/11 at 9:50 A.M., she indicated the seventh dose of Cipro was not given as ordered.</p> <p>A Physician's Order, dated 5/10/10, indicated, "...Take B/P (blood pressure) every day..."</p> <p>Review of the clinical record from 9/1/11 through 11/19/11 lacked documentation of the following 24 blood pressure results: 9/17/11, 9/20/11, 9/23/11, 9/27/11, 9/30/11, 10/3/11, 10/4/11, 10/7/11, 10/8/11, 10/9/11, 10/10/11, 10/18/11, 10/22/11, 10/23/11, 10/24/11, 10/26/11, 10/27/11, 10/28/11, 10/29/11, 10/30/11, 10/31/11, 11/1/11, 11/3/11, 11/6/11</p> <p>Resident # D's care plan, updated 10/11/11, indicated, "...HTN (hypertension)...Administer my medication as ordered..."</p> <p>Interview with the DON on 11/21/11 at</p>				

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	<p>2:30 P.M., she indicated she could not locate any additional blood pressure readings for Resident # D.</p> <p>4. During medication pass on 11/19/11 at 8:55 P.M., LPN # 3 administered Levofloxacin 500 mg, 1 pill to Resident # H.</p> <p>Upon reconciliation of the medications, it was noted that the Levaquin (Levofloxacin) was scheduled to be administered at 5:00 P.M.</p> <p>During interview with RN # 2 on 11/20/11 at 2:30 P.M., she indicated the timing of the Levaquin was late since it was scheduled to be given at 5:00 P.M.</p> <p>5. The clinical record for Resident #B, reviewed on 11/19/11 at 6:23 p.m. indicated diagnoses of, but not limited to, diabetes mellitus, PVD (peripheral vascular disease), and osteomyelitis.</p> <p>A Physician Order, dated 10/1/11, indicated, "...Accu-checks AC and HS...Aspart Insulin Sliding Scale 170-180=2u (units), 181-200=4u, 201-250=6u, 251-300=8u, 301-350=10u, 351-400=12u, 401-450=14u...."</p> <p>Review of the October 2011 and November 2011, Medication Administration Record (MAR) indicated</p>			

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	<p>incorrect sliding scale coverage a total of 6 occasions for the following Accu Check results:</p> <p>11/13/11 at 5:00 p.m., Accu Check result 170. The clinical record indicated the Resident received 0 units but should have received 2 units.</p> <p>11/8/11 at 9:00 p.m., Accu Check result 170. The clinical record indicated the Resident received 0 units but should have received 2 units.</p> <p>11/4/11 at 5:00 p.m., Accu Check result 189. The clinical record indicated the Resident received 2 units but should have received 4 units.</p> <p>10/4/11 at 8:00 a.m., Accu Check result 174. The clinical record indicated the Resident received 0 units but should have received 2 units.</p> <p>10/3/11 at 9:00 p.m., Accu Check result 177. The clinical record indicated the Resident received 0 units but should have received 2 units.</p> <p>10/1/11 at 9:00 p.m., Accu Check result 181. The clinical record indicated the Resident received 0 units but should have received 4 units.</p>				

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	<p>Review of a facility policy, titled "Medication Administration", dated May, 2008, indicated, "...Medications must be administered in a timely manner and in accordance with the attending physicians written/verbal orders....The individual administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified...before the medication is administered...."</p> <p>A facility policy, titled "Pain Management Flow Sheet", dated Nov. 2009, indicated, "...The Pain Management Flow Sheet is used when any of the four situations should occur:...2. The resident is receiving PRN (as needed) narcotic pain medications...."</p> <p>Review of a facility policy, titled "Vital Statistics Sheet", dated March 2011, indicated, "...When:...per physician order...Record...BP...in the appropriate columns...."</p> <p>This federal tag relates to complaint IN00100117.</p> <p>3.1-35(g)(2)</p>				

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F0425 SS=D	<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 interview and record review, the facility failed to ensure the ordered medications were available for 2 of 6 residents reviewed for medications in a sample of 6.</p> <p>Residents: # E, # G</p> <p>Findings include:</p> <p>1. The clinical record for Resident # G, reviewed on 11/19/11 at 6:40 P.M., indicated diagnoses of, but not limited to: chronic anxiety, chronic renal insufficiency, and femur fracture.</p> <p>Review of the November 2011, MAR (Medication Administration Record)</p>	F0425	<p>It is the intent of this Facility to provide services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the Facility. What corrective action will be done by the Facility? Residents G and E have been assessed; no adverse reaction. How will the Facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? Medications and treatments reconciled to orders audit completed. No other residents were identified. What measures will be put into place to ensure this practice does not recur? The Facility reviewed its policy and found it to be sufficient. Staff re-educated regarding protocol</p>	12/20/2011

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	<p>indicated Resident # G did not receive her scheduled Alprazolam on 11/14/11 PB (prior to bed), 11/15/11 PB, 11/16/11 UR (upon rising) &amp; PB, and 11/17/11 UR.</p> <p>The November 2011, MAR further indicated, "...11/14/11 Xanax (Alprazolam) 0.25 pharm (pharmacy) notified. Await Rx (prescription) authorization...11/15/11 Xanax 0.25 physician &amp; pharm notified. Awaiting Rx auth...11/16/11 Xanax 0.25 pharm notified. Awaiting Rx auth..."</p> <p>During interview with the Administrator on 11/20/11 at 4:30 P.M., she indicated the facility changed pharmacy providers on 11/1/11.</p> <p>On 11/21/11 at 12:10 P.M., the DON indicated the facility had to obtain new prescriptions for the entire resident population due to the pharmacy switch over.</p> <p>2. The clinical record for Resident # E, reviewed on 11/19/11 at 10:05 P.M., indicated diagnoses of, but not limited to: knee infection, heart disease, and osteoarthritis.</p> <p>Review of the November 2011, MAR indicated Resident # E did not receive his scheduled Vitamin C on 11/13/11,</p>		<p>for if medications not available and use of emergency medication box.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?Director of Nursing or designee will conduct audits of Medication Administration Records 5 times weekly. Audits will be submitted to Mission Driven Quality Assurance Committee monthly times 6. Then, after 3 months of no defciency with audits, committee will determine whether further monitoring is necessary or if the monitoring can be stopped.</p>		

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NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN46635
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>11/14/11, and 11/15/11</p> <p>The November 2011, MAR further indicated, "...11/17/11 Vitamin C 1000 mg, med (medication) not available, pharmacy, MD aware missed dose..."</p> <p>Further review of the November 2011, MAR indicated Resident # E did not receive his Vitamin B 12 on 11/14, 11/15, 11/16, and 11/17/11.</p> <p>The November 2011, MAR further indicated, "...11/17/11 Vitamin B 12, med not available, pharm call, MD aware missed dose..."</p> <p>During interview with the DON on 11/21/11 at 12:10 P.M., she indicated the facility had switched pharmacy providers from an Indiana provider to a Michigan provider which resulted in having to re-script the entire resident population.</p> <p>Review of a facility policy titled "Medication Administration", dated May 2008, indicated, "...Medications must be administered in a timely manner and in accordance with the attending physicians written/verbal orders...."</p> <p>This federal tag relates to complaint IN00100117.</p>			

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NAME OF PROVIDER OR SUPPLIER  SANCTUARY AT HOLY CROSS--INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 17475 DUGDALE DR SOUTH BEND, IN46635		
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	3.1-25(a)				