STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155298		04/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PYRAMID POINT POST-ACUTE REHABILITATION CENTER	8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260

(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
F 000 Bldg. 00	This visit was for the Investigation of Complaints IN00168938 and IN00170341. Complaint IN00168938 Substantiated. Federal /State deficiencies related to the allegations are cited at F333, F425 and F514. Complaint IN00170341 Unsubstantiated due to lack of evidence. Survey dates: April 9, 10 & 13, 2015 Facility Number: 000195 Provider Number: 155298 AIM Number: 100267690 Census Bed Type: SNF/NF: 54 Total: 54 Census Payor Type: Medicare: 5 Medicaid: 35 Other: 14 Total: 54 Sample: 9	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed by Tammy Alley RN on April 15, 2015.			
F 333 SS=D Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview the facility failed to ensure a resident was free from medication error, in that when the physician ordered medication to be administered "as needed," the nursing staff gave the resident the medication routinely, two times a day from August 6, 2014 thru December 26, 2014. In addition, when there was a clarification of how to administer the medication to the resident, the resident did not receive the prescribed doses. This deficient practice affected 1 of 4 residents reviewed for medication administration of a controlled substance in a sample of 9. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 04-09-15 at 12:45 p.m.	F 333	F333 ·Resident A medication order was changed toroutine on 12.26.15. No other residentswere affected. ·All residents receiving prn antianxiety andantipsychotic medication were audited in January and on April 20, 2015 with no discrepancies noted. · Nurses will be in-serviced on EMR userStandards policy by May 5, 2015. All neworders will be verified by the DON or designee. Any discrepancies will be will be immediately corrected and reported tothe DON. All findings will be reported to the QA committee monthly. ·Consultant Pharmacist will do a monthly randomreview of residents receiving prn medications. Pharmacist will report hisfindings to the DON. All findings will then be reported to the QA committeemonthly on an ongoing basis.	05/06/2015

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	Diagnoses included, but were not limited to, head injury, anxiety, depressive disorder, communication deficit, a history of alcohol dependency and hypertension. These diagnoses remained current at the time of the record review. Resident "A" was admitted to the facility with physician orders which included Clonazepam (an anti-anxiety medication) 0.5 mg (millegrams) two times a day prn (as needed) for anxiety. A review of the resident's Plan of Care, originally dated 08-08-14, indicated "Problem - Chronic History (Underlying Diagnoses), Manifested by anxious complaint about care - nervous complaints. Kolonpin [sic]." The facility "Interdisciplinary Assessment and Progress Note," dated 08-08-14, indicated, "Psychological Status - Behavior Review - Existing anti-anxiety agent Kolopin [sic] prn [as needed] 0.5 [millegrams] - behavior target - anxiety." A review of the "Consultant (Pharmacy) Report," dated December 1, 2014 through December 23, 2014 indicated, "[Name of resident] has received frequent doses of a PRN anxiolytic medication, Clonazepam 0.5 mg BID [two times a day] prn, in			

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	December." The physician response to this report, dated 12-26-14 instructed the nursing staff to "Give BID scheduled - GRD [gradual dose reduction] failed." This physician order was signed and dated 12-26-14. The resident record contained a report titled, "Report of Incident SBAR [Situation, Background, Assessment, Request] - Medication Regimen Issue," dated 12-24-14 and indicated the following: "Situation - I am calling about a medication [name of resident] received. The following Medication/dose Clonazamen [sic] 0.5 mg at 9:00 p.m. and 9:00 a.m. on 08-26-14 through 12-24-14. Clonazepam 0.5 mg on admit was scheduled BID [two times a day]. No orders but new script on 08-26-14 and 09-26-14 given and reads BID PRN. Order to change to what last script says. Made med. [medication] BID PRN." A review of the "Resident Medication Administration Record," for August 2014 indicated the medication was transcribed as Clonazepam 0.5 mg tablet dispensed. SIG: Give 1 tablet (0.5 mg) by oral route 2 times per day as needed. Start Date 08-06-14. The nurse then transcribed the			

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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260	

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	medication to be given at 9:00 a.m. and 9:00 p.m. A review of the "Controlled Substance Record," from 08-06-14 through 10-05-14, the resident received the medication two times daily at 9:00 a.m. and 9:00 p.m. rather than "as needed." Further review of the "Controlled Substance Record" lacked documentation the resident received the medication on 10-05-14, 10-06-14, 10-18-14, 11-08-14, 11-22-14, 12-23-14, 12-24-14, 12-25-14 or 12-26-14. The resident record contained an additional report titled, "Report of Incident SBAR - Medication Regimen Issue," dated 02-10-15 and indicated the following: "Situation - I am calling about a medication related concern [name of resident] did not receive the following medication/dose: Clonazepam 0.5 mg po [by mouth] two times a day. Transcription error when order received and entered. Problem "Clonazepam 0.5 mg po BID from 01-13-15 to 01-28-15. Resident without any complaints voiced. No increase or decreased s/s [signs or symptoms] of anxiety. Up in W/C [wheelchair] without any concerns noted."			

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	A review of the "Controlled Substance Record," from 01-13-15 through 01-28-15 indicated the resident did not receive the medication as prescribed on 01-13-15 at 9:00 a.m., 01-17-15 at 9:00 a.m., 01-18-15 at 9:00 p.m., and 01-23-15 at 9:00 p.m. Further review of the "Controlled Substance Records," indicated the resident received the medication 3 times on 01-30-15 even though the Medication Administration Record for the month of January 2015 contained documentation the medication was dispensed two times, and 4 times on 03-08-15 even though the Medication Administration Record indicated the medication was dispensed two times. The "Psychiatric Assessment," dated 02-27-15, acknolwged the medication changes as "12/2014 Klonopin changed to PRN and then changed back to scheduled at 0.5 mg po BID." A review of the facility "SigmaCare EMR [Electronic Medical Record] User Standards," on 04-13-15 at 7:10 a.m., and dated August 2012, indicated the following: "Purpose - To provide a method of			

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	writing, obtaining physician orders, and completing medication/treatment passes efficiently and accurately. To provide user access as required to complete job assignments." "Telephone orders: ... Orders will be entered electronically,... Physicians will sign the orders electronically, ... DON [Director of Nurses]/ designee will review new orders daily for accuracy and completeness." "Physician Orders: Physicians may enter orders electronically,... Physicians will sign new and monthly renewal orders electronically,... DON/designee will review new orders daily for accuracy and completeness." The record lacked documentation or notification by the Pharmacist to the physician of the significant medication error for 4 1/2 months in regard to the excessive duration for the medication given. During an interview on 04-10-15 at 3:00 p.m., the Interim Director of Nurses indicated she was unaware of the extent of the medication error. This Federal tag relates to the investigation of Complaint IN00168938.			

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	3.1-25(b)(9) 3.1-48(a)(2) 3.1-48(c)(2)			
F 425 SS=D Bldg. 00	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. 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. 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 the facility failed to ensure the pharmacy collaborated and provided consultation to the nursing staff and primary physician with the identification of an anti-anxiety medication used in excessive duration, in that when a resident was admitted to the facility with a physician ordered medication to be administered on an "as needed basis," the pharmacist did not	F 425	·Resident A medication order was changed toroutine on 12.26.15. No other residentswere affected. ·All residents receiving prn antianxiety andantipsychotic medication were audited in January and on April 20, 2015 with no discrepanciesnoted. ·The pharmacy will provide the consultingPharmacist a list of all prn medications delivered to the	05/06/2015

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	identify or notify the facility of the irregularity use of an anti-anxiety medication being administered on a scheduled/routine basis. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 04-09-15 at 12:45 p.m. Diagnoses included, but were not limited to, head injury, anxiety, depressive disorder, communication deficit, a history of alcohol dependency and hypertension. These diagnoses remained current at the time of the record review. At the time the resident was admitted to the facility, physician orders included instructions to the nursing staff to dispense Clonazepam (an anti-anxiety medication) 0.5 mg (millegrams) two times a day prn (as needed) for anxiety. The resident's Plan of Care, originally dated 08-08-14, indicated "Problem - Chronic History (Underlying Diagnoses), Manifested by anxious complaint about care - nervous complaints. Kolonpin [sic]." A review of the facility "Interdisciplinary Assessment and Progress Note," dated 08-08-14, indicated, "Psychological Status - Behavior Review - Existing		facility for themonth. Consultant Pharmacist will review the list and the resident MARs for anydiscrepancies and report his findings to the DON. ·DON will report the findings to the QA committeemonthly on an ongoing basis.	

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	anti-anxiety agent Kolopin [sic] prn [as needed] 0.5 [millegrams] - behavior target - anxiety." A review of the monthly Pharmacy review contained in the resident record lacked identification of the medication being used in an excessive dosage and excessive duration. The "Consultant (Pharmacy) Report," dated December 1, 2014 through December 23, 2014 indicated, "[Name of resident] has received frequent doses of a PRN anxiolytic medication, Clonazepam 0.5 mg BID [two times a day] prn, in December." The resident record contained a report titled, "Report of Incident SBAR [Situation, Background, Assessment, Request] - Medication Regimen Issue," dated 12-24-14 and indicated the following: "Situation - I am calling about a medication [name of resident] received. The following Medication/dose Clonazamen [sic] 0.5 mg at 9:00 p.m. and 9:00 a.m. on 08-26-14 through 12-24-14. Clonazepam 0.5 mg on admit was scheduled BID [two times a day]. No orders but new script on 08-26-14 and 09-26-14 given and reads BID PRN. Order to change to what last script says.			

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	Made med. [medication] BID PRN." A review of the "Resident Medication Administration Record," for August 2014 indicated the medication was transcribed as Clonazepam 0.5 mg tablet dispensed. SIG: Give 1 tablet (0.5 mg) by oral route 2 times per day as needed. Start Date 08-06-14. A review of the "Controlled Substance Record," from 08-06-14 through 10-05-14, the resident received the medication two times daily at 9:00 a.m. and 9:00 p.m. rather than as prescribed. The record lacked documentation or notification by the Pharmacist to the facility nursing staff or the physician of the excessive duration and frequency of the administration of the anti-anxiety medication until December 2014. This Federal tag relates to the investigation of Complaint IN00168938. 3.1-25(e)(1) 3.1-25(h) 3.1-25(i)			
F 514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on			

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	each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview the facility failed to ensure the accuracy of physician orders, in that when the physician ordered medication to be administered "as needed," the nursing staff incorrectly transcribed the order to be given as routinely for 1 of 4 residents reviewed for medication accuracy and reconciliation. (Resident "A"). Findings include: The record for Resident "A" was reviewed on 04-09-15 at 12:45 p.m. Diagnoses included, but were not limited to, head injury, anxiety, depressive disorder, communication deficit, a history of alcohol dependency and hypertension. These diagnoses remained current at the time of the record review. Resident "A" was admitted to the facility with physician orders which included Clonazepam (an anti-anxiety medication)	F 514	·Resident A medication order was changed toroutine on 12.26.15. No other residentswere affected. ·All residents receiving prn antianxiety andantipsychotic medication were audited in January and on April 20, 2015 with no discrepancies noted. · Nurses will be in-serviced on EMR userStandards policy by May 5, 2015. All neworders will be verified by the DON or designee. Any discrepancies will be will be immediately corrected and reported tothe DON. All findings will be reported to the QA committee monthly. ·Consultant Pharmacist will do a monthly review of residents medications. Pharmacist will report hisfindings to the DON. All findings will then be reported to the QA committeemonthly on an ongoing basis.	05/06/2015

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	0.5 mg (millegrams) two times a day prn (as needed) for anxiety. The facility "Interdisciplinary Assessment and Progress Note," dated 08-08-14, indicated, "Psychological Status - Behavior Review - Existing anti-anxiety agent Kolopin [sic] prn [as needed] 0.5 [millegrams] - behavior target - anxiety." A review of the "Consultant (Pharmacy) Report," dated December 1, 2014 through December 23, 2014 indicated, "[Name of resident] has received frequent doses of a PRN anxiolytic medication, Clonazepam 0.5 mg BID prn, in December." The physician response to this report, dated 12-26-14 instructed the nursing staff to "Give BID scheduled - GRD [gradual dose reduction] failed." This physician order was signed and dated 12-26-14. The resident record contained a report titled, "Report of Incident SBAR [Situation, Background, Assessment, Request] - Medication Regimen Issue," dated 12-24-14 and indicated the following: "Situation - I am calling about a medication [name of resident] received. The following Medication/dose Clonazamen [sic] 0.5 mg at 9:00 p.m. and 9:00 a.m. on 08-26-14 through			

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	12-24-14. Clonazepam 0.5 mg on admit was scheduled BID [two times a day]. No orders but new script on 08-26-14 and 09-26-14 given and reads BID PRN. Order to change to what last script says. Made med. [medication] BID PRN." A review of the "Resident Medication Administration Record," for August 2014 indicated the medication was transcribed as Clonazepam 0.5 mg tablet dispensed. "SIG: Give 1 tablet [0.5 mg] by oral route 2 times per day as needed. Start Date 08-06-14." The nurse then transcribed the medication to be given at 9:00 a.m. and 9:00 p.m. A review of the "Controlled Substance Record," from 08-06-14 through 10-05-14, the resident received the medication two times daily at 9:00 a.m. and 9:00 p.m. rather than "as needed." The resident record contained an additional report titled, "Report of Incident SBAR - Medication Regimen Issue," dated 02-10-15 and indicated the following: "Situation - I am calling about a medication related concern [name of resident] did not receive the following medication/dose: Clonazepam 0.5 mg po [by mouth] two times a day. Transcription error when order received			

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NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260	

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	and entered. Problem "Clonazepam 0.5 mg po BID from 01-13-15 to 01-28-15. Resident without any complaints voiced. No increase or decreased s/s [signs or symptoms] of anxiety. Up in W/C [wheelchair] without any concerns noted." A review of the "Controlled Substance Record," from 01-13-15 through 01-28-15 indicated the resident did not receive the medication as prescribed on 01-13-15 at 9:00 a.m., 01-17-15 at 9:00 a.m., 01-18-15 at 9:00 p.m., and 01-23-15 at 9:00 p.m. During an interview on 04-10-15 at 3:00 p.m., the Interim Director of Nurses verified the transcription error of the licensed nurse. A review of the facility "SigmaCare EMR [Electronic Medical Record] User Standards," on 04-13-15 at 7:10 a.m., and dated August 2012, indicated the following: "Purpose - To provide a method of writing, obtaining physician orders, and completing medication/treatment passes efficiently and accurately. To provide user access as required to complete job assignments."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/13/2015
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	"Telephone orders: ... Orders will be entered electronically,... Physicians will sign the orders electronically, ... DON [Director of Nurses]/ designee will review new orders daily for accuracy and completeness." "Physician Orders: Physicians may enter orders electronically,... Physicians will sign new and monthly renewal orders electronically,... DON/designee will review new orders daily for accuracy and completeness." This Federal tag relates to the investigation of Complaint IN00168938. 3.1-50(a)(2)			