

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/17/2015
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NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00174690.</p> <p>Complaints IN00174690-Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F514.</p> <p>Survey Dates: June 16 & 17, 2015</p> <p>Facility number: 000083 Provider number: 155166 AIM number: 100289670</p> <p>Census bed type: SNF/NF: 145 Total: 145</p> <p>Census payor type: Medicare: 16 Medicaid: 118 Other: 11 Total: 145</p> <p>Sample: 4 Supplemental sample: 2</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a post survey desk review on or after July 10, 2015	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 record review and interview, the facility failed to ensure Physician's Orders were followed, related to a medication not given as ordered by a resident's Physician, for 1 of 5 residents reviewed for medications in a total sample of 4 and supplemental sample of 2. (Resident #E)</p> <p>Finding includes:</p> <p>Resident #E's record was reviewed on 06/16/15 at 12:13 p.m. The resident's diagnoses included, but were not limited to, rhabdomyolysis (skeletal muscle tissue disease) and Parkinson's disease.</p> <p>A Physician's Order, dated 05/28/15 at 3 p.m., indicated an order for Mobic (nonsteroidal anti-Inflammatory) 7.5 milligrams (mg) daily.</p>	F 0282	<p>F282</p> <p>SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · Resident #E's physician was notified that the medication was not given as ordered. Resident #E receives his medication as ordered. How will you identify other residents</p>	07/10/2015

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	<p>The medication card, indicated 14 tablets of Mobic was delivered from the Pharmacy on 05/29/15, and 10 tablets of the Mobic had been taken from the medication package.</p> <p>The Medication Administration Record (MAR), dated 05/15, indicated the resident received the Mobic as ordered on May 30 and 31, 2015.</p> <p>The Mobic had not been transcribed onto the MAR, dated 06/15. The count of the medication indicated there were eight additional tablets taken from the medication card after 05/31/15, which if the resident had received the Mobic as ordered, the total amount of tablets used would have been 17 tablets. The MAR lacked documentation to indicate which dates in June the Mobic was or was not given due to the medication had not been transcribed onto the MAR.</p> <p>During an interview on 06/16/15 at 12:13 p.m., the Medical Records Nurse indicated the Mobic had not been transcribed onto the 06/15 MAR. She indicated she was unable to determine which day the resident received or did not receive the Mobic. She indicated she could not explain how the Mobic was administered in June without the</p>		<p>having the potential to be affected by the same deficient practice and what corrective action will be taken · All residents have the potential to be affected by the alleged deficient practice. · Physician's orders for all residents have been reviewed by the Unit Managers for accuracy and updated as indicated. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur · The Interdisciplinary Team will review physician's orders for all admissions, readmissions, and significant changes during clinical meeting and update as indicated. · The Unit Manager/Designee will review the physician's orders prior to use at the beginning of the month to ensure the MAR records are complete per physicians order. · The Interdisciplinary Team and nurses will be educated on Documentation on the MAR, Transcription of Physician Orders and following Physicians Orders by the CEC/designee by 7/10/15. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place · The Unit Managers will complete the "MAR/TAR Audit tool" will be utilized weekly x 4, then monthly ongoing thereafter</p>	

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F 0514 SS=D Bldg. 00	<p>medication being transcribed on the MAR.</p> <p>A facility policy, titled, "Medication Pass Procedure", dated 03/13 and received from the Staff Development Coordinator (SDC) as current, indicated, "...Medications checked 3 times to verify order with label..."</p> <p>A facility policy, titled, "Matrix Physician's Orders", dated 06/14 and received from the SDC as current, indicated, "...Each new order will be transcribed onto the current MAR...Nursing managers and/or designated nurses will review these physician order report (re-caps) for accuracy, order omissions, and obtain any necessary order clarifications..."</p> <p>This Federal Tag relates to complaint IN00174690.</p> <p>3.1-35(g)(2)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on</p>		<p>for at least 6 months. · If a threshold of 95% is not met an action plan will be created. · Data will be submitted to the CQI Committee for review and follow up. · Noncompliance with facility procedures may result in disciplinary action.</p>	

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	<p>each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>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.</p> <p>Based on record review and interview, the facility failed to ensure residents' clinical records were complete and accurate, related to Medication Administration Records (MAR), for 2 of 4 residents reviewed for medications in a total sample of 4 (Residents #B and #E) and 1 resident in a supplemental sample 2. (Resident #G)</p> <p>Findings include:</p> <p>1. Resident #B's record was reviewed on 06/16/15 at 1:10 p.m. The resident's diagnoses included, but were not limited to Parkinson's disease, liver transplant, and kidney disease.</p> <p>The resident's Physician's Orders included the following medications: 01/06/15-Protonix (stomach medication) 40 mg (milligram) daily at 6 a.m. 01/106/15-Synthroid (thyroid medication) 75 micrograms, daily at 6</p>	F 0514	<p>F514 Clinical Records</p> <p>The facility must maintain clinical records on 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. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice · There is no corrective action for Resident B as he no longer resides at the facility. · Resident E and Resident G are currently receiving medication as ordered by their physicians.</p>	07/10/2015

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	<p>a.m.</p> <p>01/06/15- Depakote 500 mg every eight hours, 6 a.m., 2 p.m., and 10 p.m.</p> <p>01/06/15- aspirin 81 mg daily at 9 a.m.</p> <p>01/06/15-multivitamin with minerals daily at 9 a.m.</p> <p>01/13/15-CellCept (anti-rejection) 1000 mg twice a day at 9 a.m. and 5 p.m.</p> <p>01/06/15-cyclosporine (immunosuppressant) 75 mg twice a day at 9 a.m. and 9 p.m.</p> <p>01/06/15-lactulose (laxative) 30 milliliters twice a day at 9 a.m. and 5 p.m.</p> <p>01/06/15-Lopressor (anti-hypertension) 25 mg every 12 hours at 9 a.m. and 9 p.m.</p> <p>01/06/15-amlodipine (cardiac) 5 mg at bedtime at 9 p.m.</p> <p>01/06/15-Xanax (anti-anxiety) 2 mg every 8 hours at 6 a.m., 2 p.m., and 10 p.m.</p> <p>01/06/15-Lexapro (anti-depressant) 20 mg daily at 9 a.m.</p> <p>01/21/15-Wellbutrin XL (anti-depressant) 150 mg daily at 9 a.m.</p> <p>A Nurses' Note, dated 02/27/15 at 4 p.m., indicated the resident had been transferred to the Hospital Emergency Room.</p> <p>A Nurses' Note, dated 03/02/15 at 7:22 p.m., indicated the resident had returned</p>		<p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</p> <ul style="list-style-type: none"> · Residents residing in the facility have the potential to be affected by the alleged deficient practice. · Licensed nurses will be educated on Documentation on the MAR, Procedure for Discontinuation of Medications and following Physicians Orders by the CEC/designee by 7/10/15. <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</p> <ul style="list-style-type: none"> · The IDT reviews the physician orders at the clinical meeting. · The Unit Manager/designee will review the MAR/TAR for any discontinued medication to ensure accuracy. · The Unit Managers/designee will audit the MAR/TAR's to ensure physician's orders are followed. · DNS/designee will assign a license nurse on weekends to review the medication administration records to ensure medications have been administered per physician orders. <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</p> <ul style="list-style-type: none"> · The Unit Managers will complete the "MAR/TAR" CQI tool will be utilized weekly x 4, then monthly ongoing thereafter 	

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	<p>to the facility from a Hospital admission from 02/27/15 through 03/02/15.</p> <p>The MAR, dated 02/15, indicated by initials the resident's 5 p.m. and 9 p.m. medications were administered to the resident on 02/27/15 and the resident's 6 a.m., 9 a.m., 2 p.m., 5 p.m., and 9 p.m. medications were administered to the resident on 02/28/15 (resident was transferred to the emergency room on 02/27/15 at 4 p.m. and admitted into the hospital).</p> <p>An interview on 06/16/15, the ADoN (Assistant Director of Nursing) and the SDC (Staff Development Coordinator) Nurse indicated the medications should not have been initialed as given on the 02/27/15 evening and on 02/28/15.</p> <p>The Physician's Recapitulation Orders, dated 05/15, included the following orders: 03/03/15-Depakote 500 mg every eight hours at 6 a.m., 2 p.m., and 10 p.m. 03/02/15-Xanax 2 mg every eight hours at 6 a.m., 2 p.m., and 10 p.m. 03/02/15-CellCept 500 mg twice a day at 9 a.m. and 5 p.m. 03/02/15-Lopressor 50 mg every 12 hours at 9 a.m. and 9 p.m. 05/01/15-cyclosporine 75 mg every morning at 9 a.m.</p>		<p>for at least 6 months. · Data will be submitted to the CQI Committee for review and follow up. · If a 95% compliance is not achieved an action plan will be developed. · Noncompliance with facility procedures may result in re-education and or disciplinary action.</p>		

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	<p>05/01/15-cyclosporine 50 mg every night at 9 p.m.</p> <p>The MAR, dated 05/15, indicated the Nurses' had not initialed the MAR, to indicated the medication had been administered, for the following days/times/medications: Depakote-05/09/15 at 6 a.m., 05/14/15 at 10 p.m., and 05/15/15 at 6 a.m. Xanax-05/09/15, 05/10/15, and 05/15/15 at 6 a.m. CellCept-05/08/15 and 05/09/15 at 5 p.m. Lopresser-05/04/15 at 9 p.m. Cyclosporine 75 mg-05/06/15 and 05/07/15 at 9 a.m. Cyclosporine 50 mg-05/04/15 at 9 p.m.</p> <p>During an interview on 06/16/15 at 2:51 p.m., the ADoN indicated there was no way of knowing if the medications had been administered or not.</p> <p>2. Resident #E's record was reviewed on 05/16/15 at 12:13 p.m. The resident's diagnoses included, but were not limited to, rhabdomyolysis (skeletal muscle tissue disease) and Parkinson's disease.</p> <p>The resident's Physician's Orders included the following medications: 05/16/15-carbidopa-levodopa 25-250 mg (Parkinson's medication) four times a day at 9 a.m., 1 p.m., 5 p.m., and 9 p.m.</p>			

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	<p>oxybutynin (urinary medication) 10 mg daily at 9 a.m.</p> <p>pramipexole (Parkinson's medication) 1.5 mg three times daily at 9 a.m., 1 p.m., and 5 p.m.</p> <p>The MAR, dated 06/15, indicated the Nurses' had not initialed the MAR, to indicated the medication had been administered, for the following days/times/medications: Carbidopa-levodopa- 06/14/15 and 06/15/15 at 9 a.m., 1 p.m., 5 p.m., and 9 p.m. Oxybutynin-06/14/15 and 06/15/15 at 9 a.m. Pramipexole-06/14/15 and 06/15/15 at 9 a.m., 1 p.m., and 5 p.m.</p> <p>During an interview on 06/16/15 at 12:13 p.m., LPN #1 indicated she had worked a double shift, days and evenings on Sunday (06/14/15) and she had administered the medications as ordered and had not signed the MAR.</p> <p>3. Resident #G's record was reviewed on 06/16/15 at 11 a.m. The resident's diagnoses included, but were not limited to ischemic heart disease and lymphoma.</p> <p>A Physician's Order, dated 05/28/15, indicated an order for aspirin 81 mg daily at 9 a.m.</p>			

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	<p>A Physician's Order, dated 06/11/15, indicated an order to discontinue the aspirin 81 mg daily at 9 a.m.</p> <p>The MAR, dated 06/15, lacked documentation to indicate the aspirin had been discontinued as ordered on 06/11/15. There were initials of Nurses in the administration boxes to indicate the resident had received the aspirin daily on 06/12/15 through 06/15/15.</p> <p>During an interview on 06/16/15 at 10:39 a.m., the West Unit Manager indicated the aspirin had been discontinued on 06/11/15 and the MAR indicated the medication had been given June 12, 13, 14, and 15, 2015.</p> <p>During an interview on 06/16/15 at 3:01 p.m., the West Unit Manager indicated she had spoken to the Nurses' and QMA scheduled those days and they had indicated the aspirin had not been given and they had forgotten to circle their initials to indicate the aspirin had not been given. She indicated the discontinuation of the aspirin had not been transcribed on the MAR, but the aspirin had been pulled from the Medication Cart and placed in the Medication Room to be returned to the Pharmacy when the order had been</p>			

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	<p>obtained to discontinue the aspirin.</p> <p>A facility policy, titled, "Medication Pass Procedure", dated 03/13 and received from the Staff Development Coordinator (SDC) as current, indicated, "...Medications checked 3 times to verify order with label...Medication administration will be recorded on the MAR...after given..."</p> <p>A facility policy, titled, "Matrix Physician's Orders", dated 06/14 and received from the SDC as current, indicated, "...Each new order will be transcribed onto the current MAR...Nursing managers and/or designated nurses will review these physician order report (re-caps) for accuracy, order omissions, and obtain any necessary order clarifications..."</p> <p>This Federal Tag relates to complaint IN00174690.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			