

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155523	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/25/2014
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NAME OF PROVIDER OR SUPPLIER RICHLAND BEAN BLOSSOM HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5911 W SR 46 ELLETTSVILLE, IN 47429
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F000000	<p>This visit was for the Investigation of Complaints IN00156608 and IN00156181.</p> <p>Complaint IN00156608 - Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00156181- Substantiated. Federal/State deficiencies related to the allegation(s) are cited at F309 and F428.</p> <p>Survey dates: September 24 & 25, 2014</p> <p>Facility number: 000558 Provider number: 155523 AIM number: 100267550</p> <p>Survey team: Susan Worsham, RN-TC</p> <p>Census bed type: SNF/NF: 74 Total: 74</p> <p>Census payor type: Medicare: 7 Medicaid: 51 Other: 16 Total: 74</p> <p>Sample: 04</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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F000309 SS=D	<p>These deficiencies reflect state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 02, 2014; by Kimberly Perigo, RN.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 observation, interview, and record review, the facility failed to ensure residents would be free from allergic reactions to medications for 1 of 4 residents reviewed for medication allergies, in that a resident was prescribed and administer a medication with a known allergy history. (Resident #A)</p> <p>Findings include:</p> <p>Review of Resident#A's clinical record on 9/24/14 at 1:30 p.m. and 9/25/14 at</p>	F000309	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p> <p>F 309 Provide Care/ Services for Highest Well Being</p> <p>Corrective action for affected resident:</p>	09/26/2014	

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	<p>10:40 a.m., indicated the facility's admission evaluation and interim care plan, dated 8/29/13, Resident #A was allergic to: penicillin (severe), potassium (hives), Ultram (hallucinations), sulfa (severe-review of doctor visit dated 7/31/13, reaction to sulfa was rash/hives), and prednisone (severe).</p> <p>Resident #A's diagnoses include, but are not limited to: Alzheimer's, muscle weakness, hypertension, Chronic itching, asthma, and anxiety disorder.</p> <p>Resident #A's initial physician order sheet, dated 8/29/13, did not indicate any allergies nor any diagnoses. The physician order sheet was signed by one nurse and a second nurse signed after review. A physician order form dated 7/01/14, indicated Resident #A was allergic to potassium and Penicillin only.</p> <p>Physician single orders indicated on 8/1/14, a new order was received to give Resident #A Bactrim (antibiotic) one tablet twice a day for 7 days for a urinary tract infection. The MAR (medication administration record) indicated on 8/2/14, Bactrim was started. Nurses notes dated 8/1/14, indicated the nurse failed to notify the family to advise them Resident #A had a urinary tract infection and an antibiotic (Bactrim) was ordered.</p>		<p>The facility continues to strive to ensure that services/care provided to the residents are adhered to as identified by facility protocol in accordance to the facility's policy and procedures. Resident# A : Allergies were immediately re-viewed on 9/9/14 with the family member and medical record, including the Medication and Treatment Administration records, and the Physician Order Sheets were updated accordingly. The licensed nursing staff were re-in serviced on facility's procedures for transcription of admission orders to include allergy listing, family notification of change in condition and new physician orders.</p> <p>Identification of others at risk:</p> <p>Immediate action was taken thus removing residents from the potential of being at risk.</p> <p>On 9/9/14 the Director of Nursing and the Assistant Director of Nursing started a chart to chart review facility wide, with a secondary review performed on 9/12/14 of all medical charts, Medication and Treatment Administration Records, and Physician Order sheets which continued to show no further issues being noted.</p> <p>Measures to ensure this deficient practice does not recur:</p>	

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	<p>Nurses notes dated 8/2/14 thru 8/8/14, documented Resident #A was having no signs or symptoms of any adverse effects to the antibiotic (Bactrim) that was being administered.</p> <p>Nurses notes dated 8/4/14, indicated Resident #A had areas on her shins related to Resident #A scratching. The Medical Doctor (MD) was notified with new orders, but lacked notification to Resident #A's family.</p> <p>Interview with the DON (Director of Nurses) 9/24/14 at 1:25 p.m., indicated when Resident #A's daughter was advised Resident #A was diagnosed with cellulitis from scratching her legs, and Resident#A was being started on Keflex (antibiotic), the daughter of Resident #A re-stated the allergies. Resident #A had and a new order dated 9/8/14, which indicated to add as allergies of the following medications: sulfa drugs, Ultram, and zoloft. Said allergies were added to the September 2014 recapulation physician order sheet and the MAR.</p> <p>On 9/9/14, a new order for additional allergies of Paxil, Benadryl, over the counter cold medications, and corticosteroids were added to Resident #A's MAR.</p>		<p>No further noncompliance of this policy has occurred since this incident. An initial in-service on proper listing of allergies was preformed on 9/9/14, a subsequent in-service for all licensed staff was preformed on 9/25/14 and included the following: Admission order transcriptions to include allergies, proper family notification as to new physician medication/treatments orders, and proper review of monthly rewrite transcriptions. Nurse aides were re- in serviced on 9/10/14 as to policy/procedures on: The Stop and Watch programs and proper identification and communication of any skin issues. The Director of Nursing and/or designee will review new admission medical records and new orders in the dialy clinical meeting to ensure that allergies are identified and documented according to facility policy.</p> <p>Monitoring of corrective action:</p> <p>Monitoring of facility protocol will be accomplished by the Director of Nursing or designee auditing 5 resident medical records monthly times 3 months and then quarterly x3 quarters to include identification and documentation of resident allergy information and physician orders to ensure that allergies are identified and considered with new physician orders.</p>	

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F000428 SS=D	<p>Review of pharmacy consultation report dated from 9/1/14 through 9/15/14, did not show Resident #A, who was admitted on 8/29/13. The 10/1/14 through 10/15/14, report did indicated Resident #A on the report, but did not have any allergies stated as indicated on the admission sheet dated 8/29/14. The report lacked documentation of notification of an allergy in regard to the physician's order dated 8/1/14, for Bactrim.</p> <p>This Federal tag relates to Complaint IN00156181.</p> <p>3.1-37(a)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a</p>		<p>The result of this monitoring will be reviewed by the Health Facility Administrator, reported and reviewed by the interdisciplinary team. Compliance will be followed by the Quality Assurance Committee quarterly.</p> <p>Plan of Correction date: 9/26/14</p>	

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	<p>licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on observation, interview, and record review, the facility's consulting pharmacist failed to identify and report the absence of allergies on the MAR (Medication Administration Record) on admission to the facility and thereafter in 1 of 4 residents reviewed for medication allergies. (Resident #A)</p> <p>Findings include:</p> <p>Review of Resident #A's clinical record on 9/24/14 at 1:30 p.m. and 9/25/14 at 10:40 a.m., indicated the facility's admission evaluation and interim care plan, dated 8/29/13, Resident #A was allergic to: penicillin (severe), potassium (hives), Ultram (hallucinations), sulfa (severe-review of doctor visit dated 7/31/13, reaction to sulfa was rash/hives), and prednisone (severe).</p> <p>Resident #A's diagnoses include, but are not limited to: Alzheimer's, muscle weakness, hypertension, Chronic itching, asthma, and anxiety disorder.</p> <p>Resident #A's initial physician order sheet, dated 8/29/13, did not indicate any</p>	F000428	<p>This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.</p> <p>F 428: Drug Regimen Review, Report Irregular, Act On</p> <p>Corrective action for affected resident:</p> <p>The facility continues to strive to ensure that Pharmacy services reviews each residents drug regimen monthly, reports any irregularities to proper personnel of the facility and physician in order for these irregularities to be acted upon in accordance with state/federal regulations and facility protocol. On 9/9/14 the Medical Record, the Medication Administration Record, the Treatment Administration Record and the Physician Order Sheets of Resident A were updated with all allergies pertinent to this resident as reported to the facility by the family member and physician</p>	10/11/2014

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	<p>allergies nor any diagnoses. The physician order sheet was signed by one nurse and a second nurse signed after review. A physician order form dated 7/01/14, indicated Resident #A was allergic to potassium and Penicillin only.</p> <p>Physician single orders indicated on 8/1/14, a new order was received to give Resident #A Bactrim (antibiotic) one tablet twice a day for 7 days for a urinary tract infection. The MAR (medication administration record) indicated on 8/2/14, Bactrim was started. Nurses notes dated 8/1/14, indicated the nurse failed to notify the family to advise them Resident #A had a urinary tract infection and an antibiotic (Bactrim) was ordered. Nurses notes dated 8/2/14 thru 8/8/14, documented Resident #A was having no signs or symptoms of any adverse effects to the antibiotic (Bactrim) that was being administered.</p> <p>On the pharmacy consultation report dated 8/1/14 through 8/21/14, did not indicate facility had given a antibiotic (Bactrim) that Resident #A was allergic to as stated in the admission evaluation done 8/29/13.</p> <p>Review of pharmacy consultation report dated from 9/1/14 through 9/15/14, did not show Resident #A, who was admitted</p>		<p>and pharmacy was notified.</p> <p>On 9/9/14 the Director of Nursing and designees did a facility wide chart review to identify and assure that all allergies and diagnosis for this resident and other residents were correct and present on the Medical Record, Medication Administration Record, Treatment Administration Record and the Physician Order Sheets, no further issues were noted.</p> <p>The Pharmacy consultant completed a drug regimen review on 9/26/14 of Resident A's medications to further assure that no other medications were contra indicated related to allergies and/or listed diagnosis.</p> <p>Identification of others at risk:</p> <p>Immediate correction was implemented no further errors were found and no residents were at risk. On 10/7/14 and 10/09/14, the pharmacy consultant completed chart reviews for residents at the facility, which included a review of resident allergies, medications, and diagnosis. No further concerns was identified.</p> <p>Measures to ensure this deficient practice does not recur:</p> <p>The Pharmacy Consultant Supervisor re-in serviced the pharmacy</p>		

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	<p>on 8/29/13.</p> <p>The 10/1/14 through 10/15/14, report did indicated Resident #A on the report, but did not have any allergies stated as indicated on the admission sheet dated 8/29/13. The report lacked documentation of notification of an allergy in regard to the physician's order dated 8/1/14, for Bactrim.</p> <p>Interview with the Director of the consulting pharmacy on 9/25/14 at 1115 a.m., indicated they follow the state operations manual and use rule 329. (In reviewing state rules there is no F329, however, in the CMS State Operations Manual, under F329 it does indicate: "Medication Regimen Review" (MRR) is a thorough evaluation of the medication regimen by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities in collaboration with other members of the interdisciplinary team.</p> <p>The pharmacist indicated he checks residents' charts monthly, looks at all medications and to see if proper</p>		<p>consultant on 10/10/14 to the expectation of monthly review of residents medical record and drug regimen including but not limited to identification of allergies, medication errors, diagnosis, and reviewing a facility census sheet when visiting to identify current residents in the facility. Physician orders and medical records of newly admitted residents will be reviewed daily in the clinical meeting to ensure allergies are identified.</p> <p>Monitoring of corrective action:</p> <p>The Director of Nursing and/or her designee has been and continues to monitor and assist with ensuring that the facility protocol of transcription of allergies and diagnosis to the Physician Order Sheets, Medication and Treatment Administration Records, and resident medical record are accurately listed and that pharmacy monthly review is done timely and reporting of irregular issues noted are being acted upon with physician/family notification.</p> <p>Monitoring of facility protocol will be accomplished by the Director of Nursing or designee auditing 5 resident medical records monthly times 3 months and then quarterly x3 quarters to include identification and documentation of resident allergy information and physician orders to ensure that allergies are</p>	

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	<p>diagnoses are noted, does GDR's (gradual dose reduction) requests when necessary and if there is a concern they forward it to both the Administrator or the DON of the facility and the Doctor. Interview with the actual pharmacist was not done due to her being out of the country.</p> <p>Documentation was not provided which indicated the pharmacist had identified Resident #A's Bactrim allergy and reported this to the facility.</p> <p>This Federal tag relates to Complaint IN00156181.</p> <p>3.1-25(h)</p>		<p>identified and considered with new physician orders.</p> <p>The Pharmacy Consultant will continue to complete monthly reviews of resident physician orders, allergy and diagnosis listings, review of the resident history and physical to include providing facility with a drug regimen review and recommendations of any irregularities to be acted upon. A Pharmacy designee will complete a peer to peer review of 25% of current residents x3 months and then quarterly x3 to ensure that the consultant pharmacist chart reviews are complete and accurate. The Administrator and Director of Nursing will be given a copy of the pharmacy consultant report and the peer to peer review and submit these findings to the Quality Assurance Committee quarterly.</p> <p>The result of this monitoring will be reviewed by the Health Facility Administrator, reported and reviewed by the interdisciplinary team. Compliance will be followed by the Quality Assurance Committee quarterly.</p> <p>Plan of Correction date: 10/11/14</p>	