

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155665	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/07/2014
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NAME OF PROVIDER OR SUPPLIER JENNINGS HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 701 HENRY ST NORTH VERNON, IN 47265
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F000000	<p>This visit was for the Investigation of Complaints #IN00142219 and #IN00131583.</p> <p>Complaint #IN00142219 - Unsubstantiated due to lack of evidence.</p> <p>Complaint #IN00131583 - Substantiated. Federal/state deficiencies related to the allegation(s) are cited at F425.</p> <p>Survey Dates: February 4, 2014 and February 7, 2014</p> <p>Facility Number: 010996 Provider Number: 155665 AIM Number: 200232210</p> <p>Survey Team: Jennifer Carr, RN - TC</p> <p>Census bed type: SNF/NF: 104 Total: 104</p> <p>Censues payor type: Medicare: 9 Medicaid: 73 Other: 22 Total: 104</p>	F000000		
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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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F000425 SS=G	<p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on Febraury 14, 2014 by Cheryl Fielden RN.</p> <p>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.</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.</p> <p>Based on observation, record review</p>	F000425	The submission of this plan of correction does not constitute an	02/27/2014	

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	<p>and interview, the facility failed to provide pharmaceutical services to meet the needs of 1 of 4 residents reviewed for pharmaceutical services. (Resident #A). The resident was not provided with requested, ordered as-needed (PRN) pain medication, which resulted in unrelieved pain. This deficiency had the potential to impact all 104 residents residing in the facility.</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 2/4/2014 at 12:30 p.m. Diagnoses included, but were not limited to, migraines (headaches), bipolar disorder, renal insufficiency, high blood pressure, and anxiety. The most recent Minimum Data Set (MDS) Assessment, dated 12/10/2013, indicated the resident's Brief Interview for Mental Status (BIMS) assessed her to be cognitively intact.</p> <p>During an interview with Resident #A, on 2/7/2014 at 11:05 a.m., she was observed to be lying in her bed with the lights out. She indicated, "I didn't get my pain pill last night. They said they didn't have any and had to order it." The resident further</p>		<p>admission of agreement to any findings listed on the 2567. We respectfully submit this plan of correction to provide proof of our continued compliance with state and federal guidelines. 1. a) The medication in question was immediately ordered for this resident. The medication was delivered per the pharmacy 2-7-14. b) The cart was reviewed per the DON, and all medications were available for this resident on 2-7-14. c) A new pain assessment was completed for this resident, as soon as the facility management team was notified of the findings. The resident had no complaints that required medication intervention @ the time of the new pain assessment. completed on 2-7-14. 2. a) A review of the survey findings were completed per the QAPI team during the monthly meeting on 2-18-14. b) Pharmacy staff completed an audit for 100% of the residents. c) The nurses were in-serviced on ordering medications per the pharmacy representative on 2-14-14. 3. a) Nursing will continue to order medications when the supply reaches a 3 day supply left in the medication cart. b) The nurses will track orders, and leave a copy of medication orders for the nurses that check in the medication order. c) The nurses checking in the daily medication delivery will check the ordered medications</p>				

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	<p>indicated that she continued to have a headache and that staff had not addressed her pain since requesting pain medication the previous evening.</p> <p>A record review of Resident #A's Physician's Orders and Medication Administration Record (MAR) for February, 2014 was conducted with LPN #1, Resident #A's nurse, on 2/7/2014 at 11:20 a.m. She indicated that Resident #A's "pain medication" order indicated, "Tramadol HCL 50mg tablet; Give 1 tablet orally 4 times a day as needed for pain." She further indicated that Resident #A had not been administered this medication since 2/1/2014. There was no documentation on either the Nurses Notes or the MAR that pain medication had been requested, that it was not available, or that it had been ordered from the pharmacy. An inventory of the locked medication box in which Resident #A's Tramadol was to be held did not have any Tramadol for the resident. LPN #1 indicated, "I'll check with pharmacy about that." She further indicated that it is the responsibility of whoever discovers that a resident's medication is running low to notify pharmacy and</p>		<p>with the delivered medications. Any discrepancies will be reported to the pharmacy for correction.4. a)The QAPI team will review results in the monthly QA meeting x 6 Months. This time period may be extended to 9 months if the QAPI team does not find that resolution is complete.5. a)Date of completion-February 27, 2014 b)We respectfully request a desk review for this finding. Please review the attached documentation as proof of compliance with F425.</p>				

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	<p>that it should be done with enough medication remaining to account for delivery time (the following day). During an interview with LPN #1 on 2/7/2014 at 2:28 p.m., she indicated that she had contacted the pharmacy and that Resident #A's Tramadol would be delivered with the "evening delivery" of medications.</p> <p>A copy of a policy and procedure entitled "Medications - Oral Administration Of" was provided by the Administrator on 2/7/2014 at 4:50 p.m. The policy and procedure related specifically to the safe and accurate administration of oral medications. She indicated that she did not have any additional policies related to pharmacy services and/or providing resident medications.</p> <p>This federal tag relates to complaint #IN00131583.</p> <p>3.1-25(a)</p>			