

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  02/05/2014
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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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F000000	<p>This visit was for the Investigation of Complaint IN00143524.</p> <p>Complaint IN00143524-Substantiated. Federal/State deficiencies related to the allegations are cited at F329, F385, and F514.</p> <p>Survey Dates: February 5, 2014</p> <p>Facility number: 000083 Provider number: 155166 AIM number: 100289670</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF/NF: 141 Total: 141</p> <p>Census payor type: Medicare: 13 Medicaid: 114 Other: 14 Total: 141</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with</p>	F000000	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 desk review on or after February 21, 2014.	

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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F000329 SS=D	<p>410 IAC 16.2.</p> <p>Quality review completed on February 6, 2014, by Janelyn Kulik, RN.</p> <p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to assess a resident's pain prior to giving a</p>	F000329	F329 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is	02/21/2014

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	<p>pain medication and failed to administer the correct pain medication after the resident had rated the pain, for 1 reviewed for pain interventions in a total sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 02/05/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to history of septic shock, chronic kidney disease, acute respiratory failure, diabetes mellitus, and coronary artery disease.</p> <p>A) A Nurses' Progress Notes, dated 01/04/14 at 11:32, indicated, "...Res (resident) c/o (complains of) pain. Res states the pain is bladder spasms...PRN (as needed) medication given..."</p> <p>A Physician's Order, indicated an order, dated 12/27/13, for acetaminophen 650 mg (milligrams) per g-tube every 6 hours as needed for pain 1-5 (pain rating) or temperature.</p> <p>A Physician's Order, indicated an order, dated 12/27/14, for tramadol (pain medication) 50 mg (milligrams) per g-tube (stomach tube) every 6</p>		<p>any drug when used in excessive dose (including duplicate therapy); or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice . The resident no longer resides in the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken . Residents residing in the facility have the potential to be affected by the alleged deficient practice. . The MAR was reviewed for all residents with a PRN pain medication for the past two weeks to ensure that the residents were assessed for pain</p>				

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	<p>hours as needed for pain 6-10 (rating of pain)</p> <p>The Medication Administration Record (MAR), dated 01/14, indicated tramadol 50 mg was given by LPN #1. There was no documentation to indicate the pain had been assessed for intensity prior to the administration of the tramadol or the time the medication had been administered.</p> <p>During an interview on 02/05/14 at 2:35 p.m., LPN #1 indicated she had given the pain medication when the resident first complained of pain. She indicated she had not documented the assessment or the time she had given the pain medication. She indicated the resident had rated the pain at a 5.</p> <p>B) Nurses' Progress Notes, dated 01/12/14 at 1:22 p.m., indicated, "Resident's family in and states resident is in a lot of pain prn meds (medication) give (sic) with little relief.."</p> <p>There was a lack of documentation in the Nurses' Progress Notes, dated 01/12/14, to indicate the type, location, and intensity of the resident's pain.</p>		<p>prior to and after dispensing the medication by the DNS/designee.</p> <ul style="list-style-type: none"> <li>Licensed nurses will be educated by the Clinical Education Coordinator/designee on the Pain Management Policy and Resident Change of Condition Policy by 2/14/14.</li> <li>The licensed nurses will be inserviced on Maintaining Complete and Accurate Clinical Records by the Clinical Education Coordinator/designee by 2/14/14.</li> <li>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</li> <li>The DNS/designee will audit the MAR daily to ensure that residents who receive PRN pain medication are assessed prior to and after dispensing the pain medication. 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</li> <li>The DNS/designee will complete the Assessment and Pain Management CQI tools three times a week for 4 weeks then weekly thereafter for at least 6 months.</li> <li>The Unit Managers will complete the Change of Condition CQI tool daily for 4 weeks then weekly for 4 weeks and monthly thereafter for at least 6 months.</li> <li>The DNS is responsible for compliance.</li> <li>Data will be submitted to the CQI Committee for review and follow</li> </ul>		

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	<p>There was a lack of documentation on the MAR, dated 01/14, to indicate the resident had been given a pain medication or an assessment of the type, location, and intensity of the pain.</p> <p>During an interview on 02/05/14 at 2:35 p.m., LPN #1 indicated she had administered the tramadol to the resident when the resident's wife first complained the resident was having pain. She indicated she did not document an assessment of the pain on the MAR.</p> <p>During an interview on 02/05/14 at 3:15 p.m., LPN #1 indicated the resident had complained of pain of his knee and shoulder. She indicated the pain was rated at a 5.</p> <p>A facility policy, dated 09/13, titled, "Pain Management", received from the Director of Nursing as current, indicated, "...Pain medications will be prescribed and given based upon the intensity of the pain...Documentation of administration of ordered PRN (as needed) pain medication will be initialed on the front of the Medication Administration Record (MAR). 7. Additional information</p>		<p>up. Action plans will be developed when thresholds are not met. Noncompliance with facility procedures may result in re-education and or disciplinary action.</p>				

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F000385 SS=D	<p>including, but not limited to reasons for administration interventions, and effectiveness of pain medication will be documented on the back of the Medication Administration (MAR), or on the facility specific pain management flow sheet..."</p> <p>This Federal Tag relates to complaint IN00143524.</p> <p>3.1-48(a)(4)</p> <p>483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician.</p> <p>The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.</p> <p>Based on record review and interview, the facility failed to ensure a resident's physician responded timely after multiple attempts were made to contact the physician, related to increased complaints of</p>	F000385	F385 Resident's Care Supervised By A Physician A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a	02/21/2014			

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	<p>pain for 1 of 3 residents reviewed for physician notification in a total sample of 3. (Resident #B, Physician #1 and Physician #2)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 02/05/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to history of septic shock, chronic kidney disease, acute respiratory failure, diabetes mellitus, and coronary artery disease.</p> <p>A) The Nurses' Progress Notes indicated:</p> <p>01/04/14 at 11:32, "...Res (resident) c/o (complains of) pain. Res states the pain is bladder spasms...PRN (as needed) medication given. (Physician #1) paged at this time. Wife at bedside."</p> <p>01/04/14 at 12 p.m., "Res cont (continue) to c/o pain r/t (related to) bladder spasms. (Physician #1) paged again d/t (due to ) no call back."</p> <p>01/04/14 at 12:36 p.m., "res wife called et (and) stated she spoke with (Physician #1) regarding Res bladder spasms et that MD stated</p>		<p>physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice . The resident no longer resides in the facility. 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> <p>Residents residing in the facility have the potential to be affected by the alleged deficient practice. . DNS/designee reviewed the medical records to ensure those physicians were notified timely when residents complained of pain. .</p> <p>Licensed nurses will be educated by the Clinical Education Coordinator/designee on the Pain Management Policy and Resident Change of Condition/Physician Notification Policy by 2/14/14. .</p> <p>The licensed nurses will be inserviced on Maintaining Complete and Accurate Clinical Records by the Clinical Education Coordinator/designee by 2/14/14. .</p> <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> <p>The DNS/designee will be contacted/notified if the</p>		

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	<p>he would immediately call facility. Res wife informed that MD has not called facility...(Physician #1) paged again."</p> <p>01/04/14 at 2 p.m., "(Physician #1) called facility regarding Res. Status given N.O. (new order) received et noted to remove foley (urinary catheter) x4 hrs (four hours)..."</p> <p>The Physician had not returned a call to the facility for 2 1/2 hours and the resident continued to complain of bladder spasm pain.</p> <p>During an interview on 02/05/14 at 2:35 p.m., LPN #1 indicated Physician #1 was not the resident's Primary Care Physician at the facility and the resident's wife had requested Physician #1 be notified about the resident's bladder spasms because he was the resident's Nephrologist (kidney specialist). LPN #1 indicated she should have notified the facility's Medical Director when the Physician did not return the calls to the facility.</p> <p>During an interview on 02/05/14 at 4 p.m., the East Unit Manager indicated a physician should be notified every 15 minutes, two or three times, then the Medical</p>		<p>physician/medical director cannot be contacted after four attempts per facility policy to meet the residents pain needs. · The DNS/designee will then contact Co-Medical Director for direction to meet residents pain needs. 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 DNS/designee will complete the Assessment and Pain Management CQI tools three times a week for 4 weeks then weekly thereafter for at least 6 months. · The Unit Managers will complete the Change of Condition CQI tool daily for 4 weeks then weekly for 4 weeks and monthly thereafter for at least 6 months. · The DNS is responsible for compliance. · Data will be submitted to the CQI Committee for review and follow up. Action plans will be developed when thresholds are not met. · Noncompliance with facility procedures may result in re-education and or disciplinary action.</p>		

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	<p>Director should be notified. She indicated the facility has two Medical Directors. She indicated the facility should have also notified the resident's Primary Care Physician.</p> <p>B) The Nurses' Progress Notes indicated:</p> <p>01/12/14 at 1:22 p.m., "Resident's family in and states resident is in a lot of pain prn meds (medication) give with little relief, MD (Physician #2) paged waiting return call."</p> <p>01/12/14 at 2:57 p.m., "MD (Physician #2) return call new orders received and noted..." This was an 1 1/2 hours after the facility had notified Physician #2)</p> <p>01/12/14 at 2:59 p.m., "new orders received for Norco (narcotic pain medication) 5/325 mg (milligrams) Q (every) 4 prn for pain..."</p> <p>During an interview on 02/05/14 at 2:35 p.m., LPN #1 indicated the resident's Primary Care Physician was one of the Medical Directors at the facility, but Physician #2 was taking the Primary Care Physician's calls. LPN #1 indicated she had called the hospital for Physician #2 four different times. She indicated</p>			

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	<p>Physician #2 had answered the phone one of the calls and told her he would call the facility back, but had not called the facility back. She indicated she had not documented all the attempts to notify Physician #2. She indicated she could have notified the facility's other Medical Director, but had not.</p> <p>A facility policy, dated 03/10, titled, "Resident Change of Condition", received from the Director of Nursing as current, indicated, "...If unable to contact the attending physician or alternate physician in a timely manner, notify the Medical director for medical intervention...If unable to reach the physician...all calls to physicians or exchanges...requesting callbacks will be documented in the medical record...If unable to contact attending physician or alternate timely, the Medical Director will be notified for response and intervention for the resident change of condition..."</p> <p>This Federal Tag relates to complaint IN00143524.</p> <p>3.1-22(b)(2)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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.</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 a resident's record was complete and accurate related to documentation of physician notification and documentation of prn (as needed) pain medication for 1 of 3 residents reviewed for medical records in a total sample of 3. (Resident #B)</p> <p>Findings include:</p>	F000514	F514 Clinical Records 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	02/21/2014

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	<p>Resident #B's record was reviewed on 02/05/14 at 9:30 a.m. The resident's diagnoses included, but were not limited to history of septic shock, chronic kidney disease, acute respiratory failure, diabetes mellitus, and coronary artery disease.</p> <p>A. The Nurses' Progress Notes indicated:</p> <p>01/12/14 at 1:22 p.m., "Resident's family in and states resident is in a lot of pain prn meds (medication) give with little relief, MD paged waiting return call."</p> <p>01/12/14 at 2:57 p.m., "MD return call new orders received and noted..." This was an 1 1/2 hours after the facility had notified Physician #2)</p> <p>During an interview on 02/05/14 at 2:35 p.m., LPN #1 indicated she had not documented the Phycsian's name she had called. She indicated she had paged Physician #2. LPN #1 indicated she had called the hospital for Physician #2 four different times. She indicated she had not documented all the attempts to notify Physician #2. She indicated when Physician #2 had not called</p>		<p>corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice . The resident no longer resides in the facility. 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> <p>Residents residing in the facility have the potential to be affected by the alleged deficient practice. . The MAR was reviewed for all residents with a PRN pain medication for the past two weeks to ensure that the residents were assessed for pain prior to and after dispensing the medication for the past 2 weeks by the DNS/designee. . Licensed nurses will be educated by the Clinical Education Coordinator/designee on the Pain Management Policy and Resident Change of Condition Policy by 2/14/14. . The licensed nurses will be inserviced on Maintaining Complete and Accurate Clinical Records by the Clinical Education Coordinator/designee by 2/14/14.</p> <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> <p>The DNS/designee will review residents who receive PRN pain medication daily to ensure that documentation is present for those residents who received PRN pain medication to</p>		

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	<p>back, she had offered the resident's family to transfer the resident to the emergency room but the family had declined the transfer. She indicated the resident's vital signs were stable and the resident had not been in any distress. LPN #1 was unable to locate documentation of the resident's vital signs.</p> <p>B) A Nurses' Progress Notes, dated 01/04/14 at 11:32, indicated, "...Res (resident) c/o (complains of) pain. Res states the pain is bladder spasms...PRN (as needed) medication given..."</p> <p>The Medication Administration Record (MAR), dated 01/14, indicated tramadol 50 mg was given by LPN #1. There was a lack of documentation to indicate what time the tramadol had been given.</p> <p>During an interview on 02/05/14 at 2:35 p.m., LPN #1 indicated she had given the pain medication when the resident first complained of pain. She indicated she had initialed the MAR, but had not documented a time when the medication had been given.</p> <p>C) Nurses' Progress Notes, dated 01/12/14 at 1:22 p.m., indicated,</p>		<p>validate that residents were assessed prior to and after dispensing the pain medication and that the physician was notified timely. 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 DNS/designee will complete the Assessment and Pain Management CQI tools three times a week for 4 weeks then weekly thereafter for at least 6 months. The Unit Managers will complete the Change of Condition CQI tool daily for 4 weeks then weekly for 4 weeks and monthly thereafter for at least 6 months. The DNS is responsible for compliance. Data will be submitted to the CQI Committee for review and follow up. Action plans will be developed when thresholds are not met. Noncompliance with facility procedures may result in re-education and or disciplinary action.</p>		

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  02/05/2014	
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	<p>"Resident's family in and states resident is in a lot of pain prn meds (medication) give (sic) with little relief.."</p> <p>There was a lack of documentation in the Nurses' Progress Notes, dated 01/12/14, to indicate the location of the resident's pain.</p> <p>There was a lack of documentation on the MAR, dated 01/14, to indicate the resident had been given a pain medication or the time the pain medication had been given.</p> <p>During an interview on 02/05/14 at 2:35 p.m., LPN #1 indicated she had administered the tramadol to the resident when the resident's wife first complained the resident was having pain. She indicated she did not document the pain medication had been given or the time the medication had been administered. She indicated the resident's pain was in his shoulder and knee. She indicated she did not have good documentation.</p> <p>This Federal Tag relates to complaint IN00143524.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						

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