

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155793	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/19/2016
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NAME OF PROVIDER OR SUPPLIER  HAMILTON TRACE OF FISHERS	STREET ADDRESS, CITY, STATE, ZIP CODE 11851 CUMBERLAND RD FISHERS, IN 46037
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00198389, IN00198335, IN00197730.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the State Residential Licensure Survey completed on 3/10/16.</p> <p>Complaint IN00198389-Unsubstantiated due to lack of evidence.</p> <p>Complaint IN00198335-Substantiated. Federal/State deficiencies related to the allegations are cited at F-280, F-282, F-333, &amp; F-465.</p> <p>Complaint IN00197730-Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency is cited.</p> <p>Survey dates: April 18 &amp; 19, 2016.</p> <p>Facility number: 012644 Provider number: 155793 AIM number: 201046710</p> <p>Census bed type:</p>	F 0000	<p>April 29, 2016</p> <p>Kim Rhoades, Director Long-Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204</p> <p>Re: Allegation of Compliance</p> <p>Dear Ms. Rhoades:</p> <p>Please find enclosed the Plan of Correction to the Complaint Survey in conjunction with the PSR conducted on April 19, 2016. This letter is to inform you that the plan of correction attached is to serve as Hamilton Trace of Fishers credible allegation of compliance. We allege compliance May 6, 2016. We are requesting a desk review for this plan of correction.</p> <p>If you have any further questions, please do not hesitate to contact me at 317-813-4444.</p> <p>Sincerely,</p> <p>Benjy Grzych H.F.A. Administrator Hamilton Trace of Fishers</p>	
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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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	<p>SNF: 44 SNF/NF: 52 Residential: 28 Total: 124</p> <p>Census payor type: Medicare: 22 Medicaid: 33 Other: 41 Total: 96</p> <p>Sample:7</p> <p>Hamilton Trace of Fishers was found to be in compliance with 42 CFR part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey.</p> <p>Quality review completed on 30576 on April 22, 2016</p>		<p>Submission of this plan of correction in no way constitutes an admission by Hamilton Trace of Fishers or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care or other services provided in this facility. The Plan of Correction is prepared and executed solely because it is required by Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey on April 19, 2016. Please accept this plan of correction as Hamilton Trace of Fishers credible allegation of compliance by May 6, 2016</p> <p>This statement of deficiencies and plan of correction will be reviewed at the June Quality Assurance/Assessment Committee meeting.</p> <p>Response to Survey Ending April 19, 2016</p>		

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F 0280 SS=D Bldg. 00	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to maintain a care plan with accurate measurable interventions for 1 of 3 residents reviewed for hydration. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 4/18/16 at 2:30 p.m. The diagnoses for Resident #C included, but were not limited to, dysphagia, dehydration, urinary incontinence, and muscle weakness.</p> <p>A care plan for Resident #C's dysphagia dated, 3/14/16, indicated a nursing staff</p>			F 0280	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident C's no longer resides in the facility</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents with dysphagia have the potential to be affected by this</p>		05/06/2016

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	<p>intervention was to assess for signs and symptoms of dehydration "(dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucus membranes, sunken eyes, constipation, fever, infection, electrolyte imbalance)".</p> <p>An interview was conducted on 4/19/16 at 10:18 a.m., with the Director of Nursing (DON). She indicated the intervention to assess for dehydration was incorrect. The signs and symptoms the nursing staff would assess Resident #C for dehydration would not include decreased urine output or concentrated urine. The DON indicated these symptoms would only be monitored if the resident had a catheter which Resident #C does not.</p> <p>A care plan policy was provided by the DON on 4/19/16 at 1:24 p.m. It indicated, "Policy Statement. An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident... Developing the Comprehensive Care Plan. 1. Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive</p>		<p>alleged deficient practice.</p> <p><b>III. The facility will put into place the followingsystematic changes to ensure that the deficient practice does not recur.</b></p> <p>Residents with dysphagia care plans were reviewedand updated as needed for accurate interventions related to hydration</p> <p>Nursing managers were re-educated on maintainingaccurate interventions for dysphagia residents related to hydration</p> <p>Comprehensive care plans are initiated uponadmission and completed within 7 days of the comprehensive assessment date</p> <p><b>IV Thefacility will monitor the corrective action by implementing the followingmeasures.</b></p> <p>DON or designee will conductan audit on residents with dysphasia for accurate hydration interventionsweekly x 12 weeks, then monthly x 3 months.</p> <p>Results of this audit will</p>	

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F 0282 SS=D Bldg. 00	<p>care plan for each resident that identifies the highest level of functioning the resident maybe expected to attain...Care Plan Interventions. 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers...Interdisciplinary Process 6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making...Revisions. 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change..."</p> <p>This federal tag relates to Complaint IN00198335. 3.1-30(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified</p>		<p>berewiewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed.</p> <p>Facility Administrator will be responsible forensuring compliance.</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is May 6, 2016.</p>		

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	<p>persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to assess for signs and symptoms of dehydration for 1 of 3 residents reviewed for hydration. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 4/18/16 at 2:30 p.m. The diagnoses for Resident #C included, but were not limited to, dysphagia, dehydration and muscle weakness.</p> <p>A dehydration care plan for Resident #C dated, 3/14/16, indicated a dehydration assessment would need to be completed on admission, quarterly, and as needed. It also indicated staff would need to encourage and document fluid intake at meals and throughout the day.</p> <p>A dysphagia (difficulty swallowing) care plan for Resident #C dated, 3/14/16, indicated the staff was to assess for signs and symptoms of dehydration.</p> <p>A Vitals Report dated, 3/12/16-4/18/16, indicated Resident #C consumed the following milliliters (ml) of fluids on 4/2/16:</p> <p>6:24 a.m., 120ml 8:14 a.m., 120ml 8:15 a.m., 240ml 1:24 p.m., 120ml</p>	F 0282	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #C no longer resides in the facility</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents that reside in the facility have the potential to be affected by the alleged deficient practice</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Licensed nurses were re-educated on assessing for signs and symptoms of dehydration and completing dehydration assessments</p> <p>Residents that consistently do not meet fluid recommendations will be assessed for signs and symptoms of dehydration.</p>	05/06/2016			

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	<p>5:05 p.m., 120ml 8:26 p.m., 120ml An interview was conducted on 4/19/16 at 10:18 a.m. with the Director of Nursing (DON). She indicated the vitals report was the amount of fluids a resident received daily. The DON indicated the staff enters the fluid consumption in the computer system. The computer system will calculate the total fluid intake for that day. It will than alert the staff the following day if the total fluid intake the day before is less than the recommended daily intake for the resident. The staff will do a dehydration assessment which includes assessing for signs and symptoms of dehydration, if the resident does not meet the recommended daily fluid consumptions.</p> <p>The DON indicated the amounts of fluids on 4/2/16 was the total amount of fluids Resident #C consumed for the staff that day. The staff should have been alerted on 4/3/16, Resident #C did not meet the recommended daily fluid consumption, and a dehydration assessment should have been completed. The DON indicated she was unable to locate a dehydration assessment for Resident #C on 4/3/16.</p> <p>A hydration policy was provided by the DON on 4/19/16 at 11:37 a.m. It indicated, "Policy It is the policy (name of company) to provide sufficient fluids</p>		<p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON or designee will conduct an audit on residents that do not meet fluid recommendations daily including weekends x 4 weeks, weekly x 8 weeks, monthly x 3 months</p> <p>Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible forensuring compliance</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is May 6, 2016</p>				

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	<p>to residents who are at risk for developing dehydration . Sufficient fluids is defined by the Centers of Medicare/Medicaid Services as; the amount of fluids needed to prevent dehydration and maintains health. The amount of fluid needed is specific for each resident and fluctuates in conditions such as; fever, vomiting, diarrhea, ect. Residents at risk: Resents with the following conditions are potentially at risk for dehydration...Functional impairments that make it difficult for a resident to drink independently, inability to reach fluids, residents dependent on staff for their fluid intake needs and residents with aphasia (partial or total loss of ability to communicate verbally)/dysphagia. Hydration assessment. Hydration assessment: completed upon admit/re-admit, quarterly with the MDS (minimum data set)schedule and will be used on a case-by-case basis by the clinical team for those residents who develop a risk factor. Monitoring: The facility will monitor fluid intake for those residents who do not consistently meet their daily minimal fluid intake requirements and are at risk for developing dehydration...Does not meet daily intake requirements. Resident does not meet the daily required fluid intake..A licensed nurse will assess the resident's physical</p>			

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F 0323 SS=D Bldg. 00	<p>condition and document in the medical record. if the resident is showing physical signs or diagnostic signs of dehydration the physician or practitioner will be notified for additional intervention..."</p> <p>This federal tag relates to Complaint IN00198335. 3.1-35(g)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on interview and record review, the facility failed to safely ambulate a resident for 1 of 1 residents reviewed for falls (Resident #C).</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 4/18/16 at 2:00 p.m. The diagnoses for Resident #C included, but were not limited to: seizures, acute embolism, deep vein thrombosis, hypertension, brain mass, and muscle weakness. A Progress Note, dated 4/09/2016 at</p>	F 0323	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b> Resident #C transfer program intervention was updated on 4/14/16 to be an assist of 2 with transfers and no longer resides in facility</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b> Residents that need 2 person assistance with transfers on therapy caseload have the potential to be affected.</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not</b></p>	05/06/2016			

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	<p>2:57 p.m., indicated, "...Res. has transferred this shift with 2 [people] x extensive assistance. Res. is weak on left side and unable to assist staff much. Gait belt used..."</p> <p>A Progress Note, dated 4/10/2016 at 11:40 a.m., indicated, "...Res. requires 1-2 [people] x extensive assist with transfers, depending on resident's ability at the time..."</p> <p>A Progress Note, dated 4/10/2016 at 11:43 p.m., indicated, "...Assist of 2 [people] with a gait belt to transfer to wheelchair to toilet. Participates in all therapies..."</p> <p>A Progress Note dated 4/11/2016 at 3:52 p.m., indicated, "...Transfers with max assist x 2 [people]. Working with skilled therapy..."</p> <p>A Physical Therapy Plan of Care, dated 4/11/16, indicated, "...Initial Assessment...Gait, Level Surfaces, Current Level...moderate assistance X 2 (26-75% with 2 people)...Short Term Goals...Gait Tasks: Distance-Surfaces...Current Level The patient ambulates 20 feet and on level surfaces requiring moderate assistance X 2 (26-75% with 2 people) with front wheeled walker with tactile and verbal instruction/cues for safety..."</p> <p>An IDT (interdisciplinary team)-IDT/Post Fall Assessment, dated 4/14/16, indicated Resident #C had a fall on 4/13/16. The</p>		<p>recur. Residents currently on therapy caseload werereviewed and if residents required 2 person assist the care plan and assignmentsheets were reviewed and updated if did not reflect current transferrecommendations from therapy Therapy director ordesignee will communicate transfer assistance recommendations in clinical standup meeting to nursing MDS or designee willupdate plan of care regarding the transfer recommendations Nursing or designee will update the assignment sheetregarding the transfer recommendations IV Thefacility will monitor the corrective action by implementing the followingmeasures. DON or designee will conduct an audit 5 x week x 4weeks, then weekly x 4 weeks, then monthly x 4 months Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed Facility Administrator will be responsible forensuring compliance V. Plan of Correction completion date. Plan of Completion date is May 6, 2016.</p>				

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	<p>form indicated, "...witnesses-if the fall was witnessed, list by whom. [name of CNA #10]-assisted res [resident] to ground....location of fall resident room-bathroom...was the fall a: near fall (resident lowered to the floor by staff or roll from low bed to floor pad...the cause of the fall was: lost strength/weakness...The activity occurring during the fall was: ambulating TO bathroom...Resident's usual ambulatory status: assist of one with/without device...summarize root cause/potential factors that could have contributed to the fall. weakness..."</p> <p>During an interview with Physical Therapist (PT) #4, on 4/19/16 at 10:19 a.m., PT #4 indicated Resident #C was currently receiving PT services and the resident seemed to be declining since his hospital stay on 4/6/16. Resident #C had brain cancer and it was presenting as a stroke, with weakness on the left side. PT #4 further indicated Resident #C needed 2 people to safely transfer and ambulate as indicated by the Physical Therapy assessment on 4/11/16. PT #4 further indicated 1 person might be able to assist Resident #C if the person was strong, larger male. PT #4 also indicated this information was relayed to nursing. On 4/19/16 at 11:05 a.m., PT #4 and PT #5 indicated Resident #C last ambulated a short distance on 4/13/16 and Resident</p>			

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	<p>#C needed assistance by 2 people on that day and one of the Physical Therapists was a male. PT #5 indicated on 4/12/16, Resident #C also needed two people to safely assist with transfers and ambulation.</p> <p>At 11:40 a.m., on 4/19/16, the Director of Nursing (DON) indicated Resident #C was being assisted, with his walker, to the bathroom by one CNA (certified nursing assistant) and the Resident lost strength and was assisted to the floor. The DON indicated prior to the fall Resident #C was being assisted by 1 staff person, because nursing did not receive information from therapy that Resident #C was a moderate assist of 2 people. The DON indicated she will review the CNA assignment sheet from that time to determine how Resident #C was to be assisted.</p> <p>On 4/19/16 at 12:15 p.m., the DON indicated the CNA assignment sheet indicated Resident #C was to assisted by 1 staff person and there was no order to transfer/ambulate with 2 people from therapy.</p> <p>During an interview with PT #4, on 4/19/16 at 12:25 p.m., PT #4 indicated therapy relays their recommendations for safe transfers/ambulation statuses to nursing and therapy does not write orders for this type of recommendation.</p> <p>3.1-45(a)(2)</p>			

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F 0333 SS=D Bldg. 00	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to administer anticonvulsant and anticoagulant medications, as ordered, to 1 of 3 residents reviewed for medication administration. (Resident #C)</p> <p>Findings include:</p> <p>The clinical record for Resident #C was reviewed on 4/18/16 at 2:00 p.m. The diagnoses for Resident #C included, but were not limited to: seizures, acute embolism and (DVT) deep vein thrombosis, hypertension (HTN), and brain mass. He was admitted to the facility from the hospital on 3/12/16, at 3:56 p.m.</p> <p>The 3/6/16 to 3/12/16 hospital records for Resident #C were reviewed. A 3/6/16, 9:32 p.m., progress note indicated, "...presents to emergency department (ER) today with stroke-like symptoms. It started about 45 minutes prior to the arrival. History is limited since the patient came in by ambulance and there was limited history from the medics. The patient says that he said he felt like he</p>	F 0333	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident C medications were delivered and administered per order on 3/13/16</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents admitted to the facility have the potential to be affected by the alleged deficient practice</p> <p><b>III. The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.</b></p> <p>Pharmacy directed re-education provided to licensed nurses on pharmacy procedures for ordering medications upon admission</p>	05/06/2016			

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	<p>was going to have "a seizure," but he does not really elaborate on that...." A 3/7/16, 12:22 p.m., progress note indicated, "History of Present Illness: ...asked to evaluate for history of lymphoma and new brain mass. This patient has history of DVT, HTN, who presented to the ER 03/06/2016 with complaints of sudden onset of coarse/violent jerks of the left upper extremity." The 3/12/16, 8:21 a.m., progress note indicated, "Imp (Impression)/Plan: Right Frontal mass: most likely Lymphoma. Anticipate bx (biopsy) Tuesday at 13:00 (1:00 p.m.) Will hold lovenox (anticoagulant medication) after Sunday. Partial onset seizure, on Keppra (anticonvulsant medication), no clinical recurrence, but w/variable facial droop, will increase dose of Keppra. H/o (history of) DVT, possible chronic hypercoag (hypercoagulation) state on warfarin, off warfarin, on lovenox for now."</p> <p>The 3/12/16, 11:02 a.m., M.D. progress note, written by Physician #7, indicated, "Seizure like activity: bilateral upper extremity, mentation intact during event...Stroke protocol performed by ER staff due to question of left sided weakness. Started on Keppra. Neurology consulted for mgmt (management)...Continue keppra on</p>		<p><b>IV The facility will monitor the corrective action by implementing the following measures.</b></p> <p>DON or designee will conduct an audit on new admission and the delivery of their medication 5 x week x 4 weeks, then weekly x 8 weeks, then monthly x 3 months</p> <p>Results of this audit will be reviewed at the monthly Quality Assurance Committee meeting and frequency and duration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible for ensuring compliance</p> <p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is May 6, 2016</p>				

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	<p>discharge per (name of physician)...H/O Afib (atrial fibrillation): pacemaker in place with EKG in paced rhythm. On coumadin, now stopped for bx (biopsy), on therapeutic lovenox....Assessment: ...Observed seizure-like activity...Plan: History of DVT Continue anticoag...Observed seizure-like activity Keppra."</p> <p>The 3/12/16, 2:39 p.m., Discharge Medication List from the hospital indicated to give 750 mg of levetiracetam (commonly known as Keppra) twice daily. It indicated the last 750 mg dose was given on 3/12/16 at 9:04 a.m. A prescription for ninety 500 mg tablets of levetiracetam was included with the Discharge Medication List. The prescription indicated to take 1.5 tablets (750 mg) by mouth twice daily. Another prescription was included for enoxaparin (Lovenox) 120/mg 0.8 mL syringe. It indicated to inject 110 mg into the skin every 12 hours for 1 day, and for the first dose to be given in the afternoon on 3/12/16 and the last dose to be given in the afternoon on 3/13/16.</p> <p>The 3/12/16 facility Physician Order indicated 750 mg of levetiracetam to be given twice daily with a start date of 3/12/16. This order was created on 3/12/16 at 5:57 p.m.</p>			

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	<p>The 3/12/16 facility Physician Order indicated 110 mg of Lovenox to be injected every 12 hours with a start date of 3/12/16. This order was created on 3/12/16 at 4:59 p.m.</p> <p>The 3/13/16 facility Physician Order indicated 750 mg of levetiracetam to be given twice daily with a start date of 3/13/16. This order was created on 3/13/16 at 10:41 p.m.</p> <p>The March, 2016 Medication Administration Record (MAR) for Resident #C was reviewed. It indicated he did not receive the p.m., dose of levetiracetam on 3/12/16 or the a.m., dose of levetiracetam on 3/13/16 because the medication was unavailable. The MAR indicated Resident #C did not receive his p.m., dose of Lovenox on 3/12/16, because they were awaiting arrival from the pharmacy. The MAR indicated he did not receive his a.m., dose of Lovenox on 3/13/16, because the medication was unavailable.</p> <p>An interview was conducted with Family Member #8, Resident #C's daughter, on 4/18/16 at 1:15 p.m. She indicated Resident #C missed his first 2 doses of Keppra after his admission to the facility. She indicated he was in the hospital for a</p>			

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	<p>seizure, so the keppra was pretty important. She indicated she was informed by the facility that the medication was not in yet.</p> <p>On 4/19/16 at 1:11 p.m., a telephone interview was conducted with Physician #7, Resident #C's physician who saw him at the hospital prior to discharge to the facility on 3/12/16 and author of the above 3/12/16, 11:02 a.m., physician progress note. He indicated he saw Resident #C in the hospital prior to discharge to the facility on 3/12/16. He indicated he expected the Keppra to be continued, as ordered, after admission to the facility. He indicated there was a problem with it getting delivered from pharmacy, but he did not know what that problem was. He indicated he went to a different pharmacy himself and brought the medication to the facility. He indicated he thought this was the day after Resident #C was admitted to the facility. Physician #7 indicated he thought Resident #C missed 2 doses of the Keppra, prior to him bringing it to the facility. He indicated it was not okay for Resident #C to miss 2 doses of his Keppra, but it was a long acting medication. He indicated he thought it was significant enough for him to go out and buy the medication and bring it to him. He indicated, since he rarely ever</p>			

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	<p>did that, he thought it was significant. He indicated, if Resident #C did not have a seizure, there was no harm done from missing the 2 doses of Keppra. He indicated there was low risk associated with Resident #C missing 2 doses of Lovenox, but if missed for days, the risk would go up exponentially.</p> <p>An interview was conducted with the DON (Director of Nursing) on 4/19/16 at 1:22 p.m. She indicated the process for obtaining ordered medications for a resident after admission from the hospital was to put the orders in the computer, and they would be sent to the pharmacy electronically. She indicated orders would also be called into the pharmacy in addition to putting them in the computer. She indicated, if the regular pharmacy was closed, they would call the back up pharmacy. She indicated medications were supposed to be "statted" (immediately) out, so should be within 4 hours. She indicated nursing should make a progress note indicating orders were verified and called into the pharmacy. She indicated if a medication, such as Lovenox or Keppra, was not received from the pharmacy for a newly admitted resident who was supposed to have their first dose the same day as admission, they would call the pharmacy and let them know they needed it stat</p>			

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	<p>(immediately). She indicated, in the case of Resident #C, she thought Physician #7 received a call that Resident #C needed his medication. She indicated, ideally, his medications would have been started out within four hours from his arrival, or "should have been anyways." On 4/19/16 at 2:15 p.m., the DON indicated she knew they put the orders in the computer, called the pharmacy, and told them they needed the medications stat, but they did not come. On 4/19/16 at 2:47 p.m., the DON indicated she spoke with the pharmacy supervisor on 3/14/16 and was informed they did not receive the faxed orders, but did receive a call from the facility.</p> <p>A telephone interview was conducted with the Pharmacy Director on 4/19/16 at 2:56 p.m. She indicated she recalled the above described situation, because it was a "big issue" over that weekend. She indicated the orders came in on Saturday, 3/12/16, after they closed at 3:00 p.m. She indicated, after 3:00 p.m., on a Saturday, the on-call pharmacist will receive a call to call the facility back, and they will get the prescription filled. She indicated they did not get a call after hours on 3/12/16 or 3/13/16. She indicated one of the pharmacy technician's received a call on 3/13/16 around 9:30 a.m., about the orders for</p>			

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	<p>Resident #C. She indicated around 2:00 p.m. on 3/13/16, the facility called back and asked about the Keppra order and their pharmacist sent it out. She indicated she knew Physician #7 was upset about this, and "this was a big ordeal." She indicated the Lovenox order came through at 4:59 p.m. on 3/12/16 and the Keppra order came through on 3/12/16 at 5:57 p.m. She indicated, "We had no information, at that time, to indicate this was stat. We received no call on 3/12 (3/12/16). That is what should have happened."</p> <p>There was no information in the clinical record to indicate the pharmacy was called on 3/12/16, regarding stat orders for Resident #C's medication.</p> <p>The DON provided the 3/13/16 (no time indicated) Packing Slip from the pharmacy on 4/19/16, at 2:54 p.m. It included the Keppra and Lovenox for Resident #C.</p> <p>The Admission &amp; Readmission Orders policy was provided by the DON on 4/19/16, at 2:14 p.m. It indicated, "Transmit orders to the pharmacy via interface....Orders transmitted after 6 PM will be delivered the next day, unless a phone call is placed....Any admission or readmission medications needed on a</p>			

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F 0465 SS=D Bldg. 00	<p>more urgent basis should be called in to the pharmacist.</p> <p>This federal tag relates to Complaint IN00198335.</p> <p>3.1-48(c)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a comfortable sleeping environment for 1 of 3 residents reviewed for environment(Resident #D).</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 4/19/16 at 10:30 a.m. The diagnoses for Resident #D included, but were not limited to, anemia, heart failure, and heart dysrhythmia according to the Admission MDS (minimum data set) assessment completed on 4/9/16.</p> <p>During an interview with Resident #D,</p>	F 0465	<p><b>I. The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.</b></p> <p>Resident #D's bed was adjusted by therapy</p> <p>Staff members were unable to be identified related to residents description of staff</p> <p><b>II. The facility will identify other residents that may potentially be affected by the deficient practice.</b></p> <p>Residents that have concerns</p>	05/06/2016

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	<p>on 4/19/16 at 11:06 a.m., Resident #D indicated about 2 weeks prior, before she moved into her current room, there was night when her bed was not appropriately positioned and she was not able to sleep most of the night. Resident #D indicated the foot of the bed was positioned above her head and the night shift staff were unable to fix the bed so she could sleep comfortably. Resident #D indicated staff came into her room several times over the course of the night trying to fix the foot of bed, so the mattress would lay flat. She indicated she felt short of breath at times since her head was positioned lower than her feet. Resident #D further indicated she even got in her recliner to try and sleep that night and so staff could see/fix her bed. Resident #D indicated her bed was not fixed until the morning when therapy came into her room, pulled up the mattress and released the latch at the foot of the bed to lower it. Resident #D was observed sitting up in a recliner with oxygen on at this time.</p> <p>The Admission MDS assessment, dated 4/9/16, indicated Resident #D had a BIMS (brief interview of mental status) of 15, which was indicative of no cognitive impairment.</p> <p>A Progress Note, dated 4/13/2016 at 9:48 a.m., indicated, "Res moved rooms 4/8/16 per res [resident] request.."</p> <p>During an interview with the Administrator,</p>		<p>related to their bedbeing comfortable have the potential to be affected</p> <p><b>III. The facility will put into place the followingsystematic changes to ensure that the deficient practice does not recur.</b></p> <p>Nursing staff were re-educated on how to operate thebed positioning and procedure to take if cannot make resident comfortable</p> <p><b>IV Thefacility will monitor the corrective action by implementing the followingmeasures.</b></p> <p>Administrator or designee will conduct audit weeklyx 12 weeks, then monthly x 3 months</p> <p>Results of this audit will bereviewed at the monthly Quality Assurance Committee meeting and frequency andduration of reviews will be adjusted as needed</p> <p>Facility Administrator will be responsible forensuring compliance</p>				

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	<p>on 4/19/16 at 12:29 p.m., the Administrator indicated there was concern brought forth a few days prior by a family friend regarding Resident #D's malfunctioning bed.</p> <p>A Resident/Family Concern/Grievance Form, dated 4/15/16, was received from the Administrator on 4/19/16 at 12:42 p.m. The form indicated, "...concern [symbol for with] functionality of bed...will continue to follow up. bed functioning correctly..."</p> <p>On 4/19/16 at 12:42 p.m., the Administrator and Maintenance Director indicated there was no maintenance requests for Resident #D's previous bed, nor had Maintenance heard about any concerns regarding bed maintenance for Resident #D's previous bed.</p> <p>At 1:04 p.m., on 4/19/16, the Maintenance Director, with the Administrator, indicated staff were inserviced during orientation to contact maintenance any time during the day or night with maintenance concerns and the phone number for someone on call was located at each nurse's station.</p> <p>During an observation with the Administrator of Resident #D's previous bed, on 4/19/16 at 1:55 p.m., the Administrator lifted the mattress at the foot of the bed and engaged the bed frame with a locking mechanism, that could be locked at various levels. The</p>		<p><b>V. Plan of Correction completion date.</b></p> <p>Plan of Completion date is May 6, 2016.</p>				

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	<p>foot was observed to be raised above the head of the bed at this time. The Administrator had to visibly push the locking mechanism back and forth to release the foot of the bed to a level position. The Administrator indicated at this time, staff should've called Maintenance if they were unable to determine how to unlock the mechanism at the foot of the bed.</p> <p>This Federal Tag relates to Complaint #IN00198335. 3.1-19(f)</p>				