

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155833	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 12315 PENNSYLVANIA STREET CARMEL, IN 46032
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00181366 and IN00184775.</p> <p>Complaint IN00181366 - Substantiated. Federal/State deficiencies cited at F309, F425, F501 and F514.</p> <p>Complaint IN00184775 - Substantiated. Federal/State deficiency cited at F157.</p> <p>Survey Dates: November 2 & 4, 2015</p> <p>Facility number: 013444 Provider number: 155833 AIM number: 201294880</p> <p>Census bed type: SNF: 23 SNF/NF: 7 Residential: 20 Total: 50</p> <p>Census payor type: Medicare: 15 Medicaid: 7 Other: 8 Total: 30</p> <p>Sample: 6</p>	F 0000	<p>Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during a Complaint (IN00181366 and IN00184775) Survey on November 4, 2015. Please accept this plan of correction as the provider's credible allegation of compliance.</p> <p>The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.</p>	

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 0157 SS=D Bldg. 00	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review was completed by 21662 on November 9, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal</p>			
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	<p>representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, record review and interview the facility failed to ensure a family member/responsible party was notified of an incident which involved the resident being pushed by another resident for 1 of 3 incident's reviewed. (Resident "B").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 11-02-15 at 9:00 a.m.</p> <p>Diagnoses included, but were not limited to, pain, glaucoma, history of urinary tract infections and conduction hearing loss. These diagnoses remained current at the time of the record review.</p> <p>During clinical record review on 11-02-15, a nurses note dated 10-15-15 at 2:00 p.m., indicated "Resident reported that she was pushed out of the way by another resident and her hand was trapped. Reported to LPN [Licensed Practical Nurse]. No injury noted at this</p>	F 0157	<p>F 157</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B - POA has been notified of the incident in which the resident was pushed by another resident.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the</p>	12/04/2015			

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	<p>time. ED [Executive Director], SSD [Social Service Director], DHS [Director of Health Services] notified of incident. Will continue to monitor."</p> <p>A review of the State reportable incident on 11-02-15 at 10:00 a.m., and dated 10-14-15 at 8:30 a.m., indicated "Resident [name of resident] reported to nurse that at around 8:30 a.m. this morning that [name of resident "D"] was propelling through the hallway and bumped into her. Residents were immediately separated. [Name of resident "D"] was reminded to use caution when propelling himself through the hallway. [Name of Resident "B"] upset that [name of Resident "D"] was going backwards in his wheelchair and bumped in to her [Resident "B"]. Says he [in regard to Resident "D"] never looks where he is going."</p> <p>On 11-02-15 the resident was observed seated in her wheelchair, and when an attempt was made to interview the resident about the incident, the resident declined and indicated the need to interview her (family member). "I told her and she will tell you what happened."</p> <p>During an interview on 11-02-15 at 2:40 p.m., the resident's (family member) indicated another resident "ran his</p>		<p>Licensed Nurses on the following guideline: Responsible Party Notification</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure compliance: Review resident incidents to ensure the POA or responsible party has been notified.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>		

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	<p>wheelchair into her on a Wednesday, and no one bothered to call and let me know. I had to hear about it from my (resident). The level of communication is bad. When I spoke with the Assistant Director of Nurses the next day [10-15-15], she told me the incident had been reported to the State Board of Health, and that she didn't need to notify me until after the investigation had been completed. That makes it worse if it was reported to the State but not to me. I had to hear about it from my mother. I called and spoke with the Administrator and he agreed with me that I had a right to know and should have been notified and that he would look in to it. I haven't heard anything from anybody since it happened. I would think if it was serious enough to report it to your office, I should have been told."</p> <p>During an interview on 11-02-15 at 3:00 p.m., the Assistant Director of Nurses indicated she spoke with the resident's family member and "I apologized to her. We were in the middle of the investigation and I told her it was reported to the State. There wasn't any injury but it wasn't reported right away to her."</p> <p>During a review of the facility policy on 11-02-15 at 2:40 p.m., titled "Guidelines for Responsible Party Notification," and</p>			

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F 0309 SS=D Bldg. 00	<p>dated 11-08-10, indicated the following:</p> <p>"Purpose: To ensure the resident's responsible party is aware of all diagnostic testing results or change in condition in a timely manner."</p> <p>"Procedure: 1. Resident assessments for change in condition, suspected injury, event of unknown origin or ordered lab and/or other diagnostic tests should be completed in a timely manner. 2. The responsible party should be notified of change in condition or diagnostic testing results in a timely manner. ... 5. Documentation of notification or notification attempts should be recorded in the resident medical record.</p> <p>This Federal tag relates to Complaint IN00184775.</p> <p>3.1-5(a)(1)</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. Based on observation, record review and</p>	F 0309	F 309	12/04/2015			

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	<p>interview the facility failed to ensure a resident received physician ordered pain medication for 1 of 3 resident's reviewed. (Resident "G").</p> <p>Findings include:</p> <p>The record for Resident "G" was reviewed on 11-02-15 at 2:00 p.m. Diagnoses included, but were not limited to, recent coronary by-pass surgery, rheumatoid arthritis, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>At the time the resident was admitted to the facility, the resident had physician orders, dated 10-19-15 for Norco (a controlled narcotic pain medication) 5/325 one tablet to be dispensed every four hours as needed for pain.</p> <p>The Initial Plan of Care, dated 10-19-15 indicated "I have complaints of pain related to my surgery and generalized arthritis." An intervention to this plan of care indicated "Administer pain medication per MD [Medical Doctor] order."</p> <p>During an interview on 11-02-15 at 1:00 p.m., the resident indicated he had severe pain and was unable to receive the</p>				<p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident G has been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all physician orders in the last 24 hours to ensure the medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1). Medication Orders and Receiving from Pharmacy - Emergency Pharmacy Services and Emergency Kits</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per</p>		

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	<p>physician ordered medication Norco. Additional interview of the resident's spouse, who was observed seated adjacent to the resident, indicated the resident could not get the medication he needed because the facility pharmacy was located in Kentucky. The spouse further indicated she and the resident were told the reason he couldn't get the medication was that the Kentucky pharmacy would not acknowledge a Nurse Practitioner or Physician Assistant signing the prescription for the controlled medication and would only fill the prescription if it had been signed by the physician.</p> <p>A review of the Medication Administration Record for October 2015, indicated the resident complained of sternal incision pain on 10-21-15 at 12:32 a.m., at the "incision site" and received Acetaminophen 325 mg [milligrams] two tablets for pain, which was "rated" by the resident as a "5" on a scale of 0-10, with "10" being the highest rated pain.</p> <p>The clinical record further indicated the resident experienced "severe incision site pain," as noted in the progress notes dated 10-22-15 at 3:43 a.m. The progress notes further indicated, "PRN [as needed] Norco unavailable at this time. Notified [Name] PA [physician assistant] on call for [Name of physician], new order</p>		<p>week times 8 weeks, then monthly times 2 months to ensure compliance: Review new physician orders to ensure the medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>				

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	<p>received for Ibuprofen [an anti-inflammatory medication] 200 mg [milligrams] by mouth times 1 now. Ibuprofen administered from EDK [Emergency Drug Kit]. Also notified [Name of physician assistant] of need for script for Norco as soon as possible. Res. [resident] aware of new order, will cont. [continue] to monitor."</p> <p>A review of the Medication Administration Record for October 2015 indicated the resident "rated" the pain at an "8."</p> <p>A review of the "Contents/Inventory List," for the Emergency Drug Kit (EDK) on 11-04-15 at 8:15 a.m., the controlled medications available for usage included Norco 5/325 as ordered by the physician.</p> <p>During an interview on 11-04-15 at 8:15 a.m., the Director of Health Services indicated the Trilogy Pharmacy was located in Kentucky and Kentucky doesn't accept Class II controlled drug prescription's written by an NP [Nurse Practitioner] or PA [Physician Assistant]. The Director further indicated the hospital case managers are informed about this practice and frequently remind the hospital staff of the need for a prescription written and signed by the physician. "The nurses usually will notify</p>			

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	<p>the physician of the need for a signed prescription at the time of admission, if the prescription was written and signed by an NP or PA from the hospital. I don't know what happened, but when [name of Resident "G"] did have pain and the nurse assessed him she called the NP and got an order for the Ibuprofen."</p> <p>During a confidential interview on 11-04-15 at 2:30 p.m., a licensed nurse indicated she was aware of the problems with the pharmacy and getting narcotics for residents with severe pain. "It's part of the Admission process by the nurse to make sure if the prescription is signed by the MD or the NP. If it's an NP we have to get ahold of our Doctor right away and get the prescription. The pharmacy is located in Kentucky and they won't accept a prescription if it's not signed by the Doctor. They won't give us access to the EDK to get the medication."</p> <p>Further interview on 11-04-15 at 10:00 a.m., the Resident indicated he felt the issue with the pain medication was now resolved, but "it shouldn't have happened to begin with. No one should have to go that many days without the medication being available."</p> <p>This Federal Tag relates to Complaint IN00181366.</p>			

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F 0425 SS=D Bldg. 00	<p>3.1-37(a)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>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. Based on observation, record review and interview the facility failed to ensure pharmaceutical services related to controlled medication for 1 of 3 residents reviewed. (Resident "G").</p> <p>Findings include:</p> <p>The record for Resident "G" was reviewed on 11-02-15 at 2:00 p.m. Diagnoses included, but were not limited</p>	F 0425	<p>F 425</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident G has been discharged.</p> <p>Identification of other residents</p>	12/04/2015

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	<p>to, recent coronary by-pass surgery, rheumatoid arthritis, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>At the time the resident was admitted to the facility, the resident had physician orders, dated 10-19-15 for Norco (a controlled narcotic pain medication) 5/325 one tablet to be dispensed every four hours as needed for pain.</p> <p>The Initial Plan of Care, dated 10-19-15 indicated "I have complaints of pain related to my surgery and generalized arthritis." An intervention to this plan of care indicated "Administer pain medication per MD [Medical Doctor] order."</p> <p>During an interview on 11-02-15 at 1:00 p.m., the resident indicated he had severe pain and was unable to receive the physician ordered medication Norco. Additional interview of the resident's spouse, who was observed seated adjacent to the resident, indicated the resident could not get the medication he needed because the facility pharmacy was located in Kentucky. The spouse further indicated she and the resident were told the reason he couldn't get the medication was that the Kentucky pharmacy would</p>		<p>having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all physician orders in the last 24 hours to ensure the medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following guidelines: 1). Medication Orders and Receiving from Pharmacy - Emergency Pharmacy Services and Emergency Kits</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure compliance: Review new physician orders to ensure the medications were received from the facility pharmacy and/or back up pharmacy in a timely manner as to not delay medication administration.</p>		

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	<p>not acknowledge a Nurse Practitioner or Physician Assistant signing the prescription for the controlled medication and would only fill the prescription if it had been signed by the physician.</p> <p>A review of the Medication Administration Record for October 2015, indicated the resident complained of sternal incision pain on 10-21-15 at 12:32 a.m., at the "incision site" and received Acetaminophen 325 mg [milligrams] two tablets for pain, which was "rated" by the resident as a "5" on a scale of 0-10, with "10 being the highest rated pain.</p> <p>Further review of the clinical record indicated the resident experienced "severe incision site pain," as noted in the progress notes dated 10-22-15 at 3:43 a.m. The progress notes further indicated, "PRN [as needed] Norco unavailable at this time. Notified [Name] PA [physician assistant] on call for [Name of physician], new order received for Ibuprofen [an anti-inflammatory medication] 200 mg [milligrams] by mouth times 1 now. Ibuprofen administered from EDK [Emergency Drug Kit] Also notified [Name of physician assistant] of need for script for Norco as soon as possible. Res. [resident] aware of new order, will cont. [continue] to monitor. The Medication</p>		<p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155833	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER WELLBROOKE OF CARMEL	STREET ADDRESS, CITY, STATE, ZIP CODE 12315 PENNSYLVANIA STREET CARMEL, IN 46032
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	<p>Administration Record for October 2015 indicated the resident "rated" the pain at an "8" on a scale of 0 - 10, with "0" being no pain and "10" the highest.</p> <p>A review of the "Contents/Inventory List," for the Emergency Drug Kit (EDK) on 11-04-15 at 8:15 a.m., the controlled medications available for usage included Norco 5/325.</p> <p>During an interview on 11-04-15 at 8:15 a.m., the Director of Health Services indicated the Trilogy Pharmacy was located in Kentucky and Kentucky doesn't accept Class II controlled drug prescription's written by an NP [Nurse Practitioner] or PA [Physician Assistant]. The Director further indicated the hospital case managers are informed about this practice and frequently remind the hospital staff of the need for a prescription written and signed by the physician. "The nurses usually will notify the physician of the need for a signed prescription at the time of admission, if the prescription was written and signed by an NP or PA from the hospital. I don't know what happened, but when [name of Resident "G"] did have pain and the nurse assessed him she called the NP and got an order for the Ibuprofen."</p> <p>During a confidential interview on</p>			

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	<p>11-04-15 at 2:30 p.m., a licensed nurse indicated she was aware of the problems with the pharmacy and getting narcotics for residents with severe pain. "It's part of the Admission process by the nurse to make sure if the prescription is signed by the MD or the NP. If it's an NP we have to get ahold of our Doctor right away and get the prescription. The pharmacy is located in Kentucky and they won't accept a prescription if it's not signed by the Doctor. They won't give us access to the EDK to get the medication."</p> <p>Further interview on 11-04-15 at 10:00 a.m., the Resident indicated he felt the issue with the pain medication was now resolved, but "it shouldn't have happened to begin with. No one should have to go that many days without the medication being available."</p> <p>A review of the facility policy on 11-04-15 at 2:30 p.m., titled "Medication Ordering and Receiving From Pharmacy," and dated 05-01-11, indicated the following:</p> <p>"Policy: Emergency pharmacy service is available on a 24 hour basis. Emergency needs for medication are met by using the facility's approved emergency medication supply or by special order from the provider pharmacy. An emergency</p>				

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	<p>supply of medications, including emergency drugs, antibiotics and controlled substances will be provided to the facility."</p> <p>"Procedures: ... G. When an emergency or starter dose of a medication is needed, the nurse unlocks the container/cabinet/breaks the container seal and removes the required medication. 1. The nurse confers with the prescriber to determine whether the order is a true emergency, i.e., order cannot be delayed until the scheduled pharmacy delivery. If the medication is a controlled substance, the prescriber either faxes a complete prescription to the facility and pharmacy or communicates the verbal order to both the nurse and directly to the pharmacist. 2. Only after verifying that the above communication has occurred, the pharmacy has received a complete prescription, and drug allergies, interactions, and other contraindications have been checked, the nurse opens the container and removes the required medication as available in the emergency kit. ... N. For controlled substances in the emergency supply: 1) a. ...a signed copy of a prescription from the attending physician or other procedure as required by state law must be faxed to the pharmacy detailing what patient received the medication. A signed facsimile of the</p>			

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F 0501 SS=D Bldg. 00	<p>prescription may be sent to the pharmacy followed by the original written prescription within seven days."</p> <p>This Federal Tag relates to Complaint IN00181366.</p> <p>3.1-25(a)(1) 3.1-25(g)(2)</p> <p>483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director.</p> <p>The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.</p> <p>Based on observation, record review and interview the facility failed to ensure and coordinate the medical care of a resident related to controlled narcotics, in which the Medical Director failed to provide a written and signed prescription for 1 of 3 residents reviewed for physician orders. (Resident "G")</p> <p>Findings include:</p> <p>The record for Resident "G" was reviewed on 11-02-15 at 2:00 p.m. Diagnoses included, but were not limited</p>	F 0501	<p>F 501</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident G has been discharged.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: The DHS or designee will</p>	12/04/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155833	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 11/04/2015
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	<p>to, recent coronary by-pass surgery, rheumatoid arthritis, hypertension and diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>At the time the resident was admitted to the facility, the resident had physician orders, dated 10-19-15 for Norco (a controlled narcotic pain medication) 5/325 one tablet to be dispensed every four hours as needed for pain.</p> <p>The Initial Plan of Care, dated 10-19-15 indicated "I have complaints of pain related to my surgery and generalized arthritis." An intervention to this plan of care indicated "Administer pain medication per MD [Medical Doctor] order."</p> <p>During an interview on 11-02-15 at 1:00 p.m., the resident indicated he had severe pain and was unable to receive the physician ordered medication Norco. Additional interview of the resident's spouse, who was observed seated adjacent to the resident, indicated the resident could not get the medication he needed because the facility pharmacy was located in Kentucky. The spouse further indicated she and the resident were told the reason he couldn't get the medication was that the Kentucky pharmacy would</p>		<p>review all new controlled narcotic orders within the past 24 hours to ensure the medical care of the resident is coordinated and the LIP (Licensed Independent Practitioner) provides a written and signed prescription.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will reeducate the licensed nurses on the following campus guideline, physician services.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee two times per week times 8 weeks then monthly times two months to ensure compliance: all new controlled narcotic orders to ensure the medical care of the resident is coordinated and the LIP (Licensed Independent Practitioner) provides a written and signed prescription.</p> <p>The results of the audit observations will be reported,</p>	

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	<p>not acknowledge a Nurse Practitioner or Physician Assistant signing the prescription for the controlled medication and would only fill the prescription if it had been signed by the physician.</p> <p>A review of the Medication Administration Record for October 2015, indicated the resident complained of sternal incision pain on 10-21-15 at 12:32 a.m., at the "incision site" and received Acetaminophen 325 mg [milligrams] two tablets for pain, which was "rated" by the resident as a "5" on a scale of 0-10, with "10" being the highest rated pain.</p> <p>The clinical record indicated the resident experienced "severe incision site pain," as noted in the progress notes dated 10-22-15 at 3:43 a.m. The progress notes further indicated, "PRN [as needed] Norco unavailable at this time. Notified [Name] PA [physician assistant] on call for [Name of physician], new order received for Ibuprofen [an anti-inflammatory medication] 200 mg [milligrams] by mouth times 1 now. Ibuprofen administered from EDK [Emergency Drug Kit] Also notified [Name of physician assistant] of need for script for Norco as soon as possible. Res. [resident] aware of new order, will cont. [continue] to monitor." The Medication Administration Record</p>		<p>reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>		

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	<p>for October 2015 indicated the resident "rated" the pain at an "8."</p> <p>Although the resident was assessed in person by the Nurse Practitioner on 10-20-15 and again on 10-21-15 a signed prescription by the resident's physician, the Medical Director, was not provided for the resident.</p> <p>A review of the "Contents/Inventory List," of the Emergency Drug Kit (EDK) on 11-04-15 at 8:15 a.m., the controlled medications available for usage included Norco 5/325.</p> <p>During an interview on 11-04-15 at 8:15 a.m., the Director of Health Services indicated the Trilogy Pharmacy was located in Kentucky and Kentucky doesn't accept Class II controlled drug prescription's written by an NP [Nurse Practitioner] or PA [Physician Assistant]. The Director further indicated the hospital case managers are informed about this practice and frequently remind the hospital staff of the need for a prescription written and signed by the physician. "The nurses usually will notify the physician of the need for a signed prescription at the time of admission, if the prescription was written and signed by an NP or PA from the hospital. I don't know what happened, but when [name of</p>			

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	<p>Resident "G"] did have pain and the nurse assessed him she called the NP and got an order for the Ibuprofen."</p> <p>During a confidential interview on 11-04-15 at 2:30 p.m., a licensed nurse indicated she was aware of the problems with the pharmacy and getting narcotics for residents with severe pain. "It's part of the Admission process by the nurse to make sure if the prescription is signed by the MD or the NP. If it's an NP we have to get ahold of our Doctor right away and get the prescription. The pharmacy is located in Kentucky and they won't accept a prescription if it's not signed by the Doctor. They won't give us access to the EDK to get the medication."</p> <p>During the Exit conference on 11-04-15 at 3:00 p.m., the facility provided "notification" with "confirmation" to the Medical Director of the need for a written and signed prescription for Resident "G" on 10-19-15, 10-22-15 and again on 10-23-15. The requests went unanswered.</p> <p>This Federal Tag relates to Complaint IN00181366.</p> <p>3.1-13(v)(1)</p>			

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F 0514 SS=D Bldg. 00	<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 complete and accurate medical records for 1 of 6 sampled residents reviewed for clinical records. (Resident "C").</p> <p>Findings include:</p> <p>The record for Resident "C" was reviewed on 11-02-15 at 10:40 a.m. Diagnoses included, but were not limited to, volume depletion - dehydration, anxiety, pneumonia, hypertension and dementia. These diagnoses remained current at the time of the record review.</p> <p>The resident returned to the facility from a recent hospitalization for pneumonia on 09-01-15.</p>	F 0514	<p>F 514 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident C has been discharged from the campus. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all residents with IV infusion orders to ensure documentation complete. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following: Trilogy Health Services Guidelines for EMAR</p>	12/04/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155833	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/04/2015
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	<p>A review of the Resident Progress notes, dated 09-04-15 at 1:40 p.m., indicated the following: "Family called concerned about residents status. Writer went and assessed res. [resident]. Res. lethargic and fatigued. Unable to arouse. Lungs diminished. No productive cough. Signs of dehydration noted. Poor skin turgor, dry mucous membrane <sic>. Res. has had poor oral fluid intake. Notified NP [Nurse Practitioner]. New orders written. D5NS [Dextrose 5% Normal Saline] 1.5 L [liters] and NS [Normal Saline] 1.5 daily."</p> <p>A review of the Dehydration Event Report, dated 09-04-15 indicated the resident had "dry mouth/sticky saliva, weakness, fatigue, pale in color with dry mucous membranes and poor skin turgor, decreased urinary output, lethargy and sleepiness." The "intervention" indicated the nurse called the Nurse Practitioner and new orders included to have a "midline placed, and start IV [interavenous] fluids D5NS at 100 ml [milliliters] per hour total of 1.5 liters to be given and starting on 09-05-15 NS at 75 mg/hr [hour] daily 1.5 liters total."</p> <p>Although the Resident Progress notes dated 09-05-15 at 3:50 a.m., indicated</p>		<p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for 5 residents will be conducted by the DHS or designee 2 times per week times 8 weeks, then monthly times 2 months to ensure compliance: review all residents with IV infusion orders to ensure documentation complete. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 4 months then randomly thereafter for further recommendation.</p>		

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	<p>"NS infusing at 75 ml/hr via RUE [right upper extremity] midline," a review of the September 2015 Medication Administration record clearly indicated the D5NS was started as ordered, however the NS to start on 09-05-15 was not charted/recorded as started, but rather indicated in the comment section "RHC [respirations have ceased]."</p> <p>During an interview on 11-04-15 at 8:15 a.m., the Director of Health Services and the Assistant Director of Nurses verified the discrepancy between the progress notes and the Medication Administration Record. The Assistant Director of Nurses indicated the nurses "chart by exception."</p> <p>This Federal tag relates to Complaint IN00181366.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			