

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155273	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2013
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NAME OF PROVIDER OR SUPPLIER CYPRESS GROVE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4255 MEDWELL DR NEWBURGH, IN 47630
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F0000	<p>This visit was for the Investigation of Complaint Number IN00122018.</p> <p>Complaint Number: IN00122018 Substantiated. Federal/state deficiencies related to the allegations are cited at F425.</p> <p>Survey Dates: January 24, 25, 2013</p> <p>Facility Number: 000173 Provider Number: 155273 AIM Number: 100290920</p> <p>Survey Team: Diane Hancock, RN TC</p> <p>Census Bed Type: SNF: 11 SNF/NF: 67 Total: 78</p> <p>Census Payor Type: Medicare: 10 Medicaid: 53 Other: 15 Total: 78</p> <p>Sample: 11</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F0000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</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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	Quality review was completed on January 28, 2013, by Jodi Meyer, RN			

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F0425 SS=D	<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 record review and interview, the facility failed to ensure routine and as needed medications were obtained from the pharmacy and given according to physician's orders, for 2 of 3 residents sampled for medication orders, in the total sample of 11. (Residents A, C)</p> <p>Findings include:</p> <p>1. Resident A's clinical record was reviewed on 1/25/13 at 9:55 a.m. The resident was admitted to the facility on 12/17/12 with diagnoses including, but not limited to, acute respiratory failure</p>	F0425	F 425 SS = D Resident A: Review of Medical Record to include Physicians orders conducted, Physician notified, and orders received for Restoril 50mg one tablet at bedtime orally. Pharmacy notified, prescription received from Physician, medication delivered to facility. Resident C: Review of Medical Record conducted. Resident C no longer resides at Cypress Grove Rehabilitation Center. A meeting with the Administrator, Director of Nursing and Pharmacy	02/14/2013			

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	<p>and multiple falls. Admission orders, dated 12/17/12, included, but were not limited to, the following: Quetiapine 50 milligrams [antipsychotic medication] one tablet at bedtime orally Warfarin 5 mg tablet one tablet by mouth daily at 1900</p> <p>Nurses' notes indicated, on 12/18/12 at 0830 [8:30 a.m.] "...On assessment of pain res. [resident] denied pain. About 30 minutes later he stated, 'his left shoulder aches.' Res. states he had x-rays and nothing was found. Able to make needs known. Informed this writer he was calling his family doctor this morning and 'she will give me meds.'...</p> <p>12/18/12 10:00 a.m., "Res. requested pain medication for all over ache and stated always has (L) [left] shoulder pain. Resident stated Tylenol not effective at all. Also requested neurontin [medication given for nerve pain] restarted and nicotene 21 mg [milligram] patch. Fax sent to physician."</p> <p>12/19/12 10:00 a.m. "New order per Dr. [name] Neurontin 300 mg TID [three times a day], Lortab [for pain] every 4 hours for pain, Nicotene 21 mg patch apply daily off @ HS [hour of sleep]..."</p> <p>Review of the Medication Administration Record [MAR] for December, 2012, indicated the following:</p>		<p>General Manager was conducted to review timeliness of medication delivery process, and utilization of the emergency drug kit.</p> <p>100 % medical record review will be conducted on current in house resident's for the past 30 days to identify residents receiving routine / as needed (PRN) Hypnotics and Pain Medications. Record review included but was not limited to, 24 hour status report, physicians orders, nurses notes, medication administration records.</p> <p>The District Education Training Director (DETD) will provide education to licensed personnel regarding Medication Administration P & P, to including but not limited to, appropriate transcription of physician orders, admission process, verification of orders, appropriate omission and refusal documentation, Psychoactive P & P, Pain Management Program, and Pharmacy Procedure P & P.</p> <p>Upon shift change, the on-coming & off-going licensed nurse will observe the medication administration record to ensure completion, appropriate documentation related to refusal / omission of medication, and accurate transcription of physicians orders. DON /Designee will call each stations Licensed Charge Nurse 30 minutes prior to the end of</p>				

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	<p>Quetiapine 50 mg tablet one tablet at bedtime orally, ordered on 12/17/12 was not documented as given on 12/18, 12/19 [blank], 12/20, 12/21 [circled, indicating not given], 12/22 [blank], 12/26 [blank]. There was no documentation regarding the Quetiapine on the reverse of the MAR or in the nurses' notes as to why it was not given.</p> <p>Warfarin 5 mg tablet, ordered on 12/17/12, not documented as given until 12/20/12</p> <p>Neurontin 300 mg by mouth three times a day, requested on 12/18/12, ordered on 12/19/12, not started until 12/20/12</p> <p>Nicotene 21 mg patch, requested on 12/18/12, ordered on 12/19/12, and not started until 12/20/12</p> <p>Lortab 5/325 mg one tablet by mouth every four hours, requested on 12/18/12, ordered on 12/19/12, not started until 12/20/12</p> <p>LPN #1 was interviewed on 1/25/13 at 11:45 a.m. He indicated medications for new admissions usually were delivered the same day. He indicated the pharmacy closed at 5:00 p.m., so later admissions might be the next day.</p> <p>Interview with the Director of Nurses [DoN] on 1/25/13 at 11:35 a.m. indicated she wasn't sure why the fax request for the medications was not followed up on by</p>		<p>each shift to review the orders obtained on the shift. Review will include the charge nurses observation of the Medication Administration Record (MAR) to ensure orders received on that shift have been transcribed accurately, and that omissions / refusals are documented appropriately. Nursing Administration will conduct a follow-up review to ensure orders received on the previous day were transcribed accurately and documentation required for omissions / refusals is appropriate.</p> <p>Review of orders, transcription, and documentation between Nursing Administration and Licensed Charge Nurses will continue every shift times 14 days, then 1 time daily random to cover all shifts times 14 days, then 1 time weekly random to cover all shifts times 14 days, then 1 time monthly ongoing random to cover all shifts.</p> <p>Identified non-compliance will result in 1:1 re-education up to & including termination. Results of above audits will be forwarded to the Quality Assurance Committee for further review & recommendations monthly as deemed appropriate.</p> <p>Completion Date: February 14, 2013</p>		

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	<p>the nurse, nor why the medications were not started timely. She indicated, if the nurse hadn't heard from the physician about a fax, a follow-up call should be made to obtain the orders. Medications should be delivered the day they are ordered if ordered early enough. Not sure why some admission medications aren't documented as being started on admission. She indicated pharmacy deliveries were sometimes later in the evening. There had been occasions when new admission orders were routed to Indianapolis [3 hours away], the hub for their pharmacy, instead of the local branch of their pharmacy and the local pharmacist was going to look into that issue.</p> <p>2. Resident C's clinical record was reviewed on 1/25/13 at 9:40 a.m. The record indicated the resident was admitted to the facility on 12/27/12 with diagnoses including, but not limited to, anxiety, chronic pulmonary disease, and status post pedestrian/motor vehicle accident with head injury and arm/shoulder injury. Admission physician's orders included, but were not limited to, the following: Potassium Iodide [SSKI] [Used to loosen and break up mucus in the airways] 1 Gm [gram]/ML [milliliter] give 5 drops orally TID [three times a day] with meals. Temazepam [Restoril] 15 mg [for sleep]</p>			

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	<p>give one capsule orally at bedtime</p> <p>Review of the resident's Medication Administration Records [MAR] for December, 2012 and January, 2013, indicated the following: The Potassium Iodide was not given from the time of admission until January 1, 2013. The Temazepam was given through 1/8/13. At that time, the MAR documentation indicated the medication was not given from 1/9/13 through 1/24/13. The initials of the person administering the medication were circled, indicating the medication was omitted. No reason was documented.</p> <p>Further review of the clinical record indicated the physician had been contacted on 1/24/13 at 8:30 p.m., by fax, of the resident not receiving the Temazepam, "Waiting for a hard script for Restoril 15 mg QHS [every night] since last 14 days." "We have been waiting for a script for his Restoril. He has not had it since last 14 days. Pharmacy said they've contacted your office. Please help us." There was no indication the facility had contacted the physician previously.</p> <p>The resident had a "hard script" [actual written prescription signed by the</p>						

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	<p>physician] on admission, but it was only written for 10 doses.</p> <p>During interview with the Director of Nurses [DoN] on 1/25/13 at 11:35 a.m., she indicated the pharmacy would not fill scheduled medications without an actual written prescription from the physician, signed. The facility cannot even access the medication through their emergency drug kit unless there is a hard script. There had been some problems with this and they had met with their pharmacist in the past week to work on the issue.</p> <p>The DoN was unable to explain why the Temazepam prescription had not been requested until 1/24/13. She indicated the resident received the Potassium Iodide in January. She indicated it had been delivered to the facility on 12/28/12 so she did not know why it was not given prior to January 1, 2013.</p> <p>3. Policies and procedures for Medication Administration, Physician's Orders, and Controlled Drugs, dated January 2001 and revised November 2012, were provided by the District Education and Training Director on 1/25/13 at 2:30 p.m. The procedures included, but were not limited to, the following: Medication Administration "Indicate refused or omitted dose by</p>			

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	<p>circling your initials in the appropriate block or as directed on the MAR.</p> <p>Indicate reason for dose omission in the Nursing Progress Notes or on the back of the MAR.</p> <p>Note: It is not acceptable to omit a dose by indicating 'NA' for Medication not Available from pharmacy. Remove a dose from Back-up Supply/Emergency Kit or contact pharmacy or on-call pharmacist and request medication to be sent ASAP [as soon as possible]. If the medication is not available, contact the physician and/or medical director for further orders..."</p> <p>Physician's Orders: "At the time each resident is admitted, the center will have physician's orders for their immediate care." "Fax all orders immediately to the pharmacy."</p> <p>Controlled Drugs "Ordering Controlled Drugs Licensed Staff 1. Order Schedule II through V drugs from the pharmacy provider in accordance with federal and state regulations and pharmacy procedures. 2. Obtain a written prescription for Schedule II drugs prior to dispensing, except in emergency situation, the prescriber may phone the pharmacist for a</p>			

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	<p>limited quantity emergency dispensing. Note: DEA [Drug Enforcement Agency] regulations require this...</p> <p>5. Remove the drug for resident use from the Emergency Kit upon authorization from the pharmacy, in the case of and emergency need for a controlled drug."</p> <p>This Federal Tag relates to Complaint Number IN00122018.</p> <p>3.1-25(a) 3.1-25(b)</p>			