

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155490	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 02/24/2021
NAME OF PROVIDER OR SUPPLIER AMBASSADOR HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 705 E MAIN ST CENTERVILLE, IN 47330		
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00348079</p> <p>Complaint IN00348079-Substantiated. A deficiency related to the allegations is cited at F551.</p> <p>Survey date: February 24, 2021.</p> <p>Facility number: 000456 Provider number: 155490 AIM number: 100288750</p> <p>Census Bed Type: SNF/NF: 67 Total: 67</p> <p>Census Payor Type: Medicare: 4 Medicaid: 63 Total: 67</p> <p>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on February 26, 2021</p>	F 0000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiency cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law.</p> <p>We are requesting a desk review for this survey.</p>	
F 0551 SS=D Bldg. 00	483.10(b)(3)-(7)(i)-(iii) Rights Exercised by Representative §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be			

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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>afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.</p> <p>(i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.</p> <p>(ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.</p> <p>§483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.</p> <p>§483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.</p> <p>§483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law.</p> <p>§483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed</p>			

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	<p>resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law.</p> <p>(i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority.</p> <p>(ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative.</p> <p>(iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.</p> <p>Based on record review and interview, the facility failed to ensure a resident's (Resident B) documented legal representative was informed of a significant change in treatment, the addition of a prescription for, and administration of, a Class II opioid narcotic, morphine sulfate, to the resident's medications, against the legal representative's wishes. 1 of 3 residents reviewed for medication approval.</p> <p>Findings Include:</p> <p>The record of Resident B was reviewed on 02/24/21 at 9:30 A.M. Diagnoses included, but were not limited to, COVID-19, pneumonia, Alzheimer's Disease, anxiety, cerebrovascular disease, psychosis, dementia with behavioral disturbance, and chronic pain.</p> <p>A quarterly Minimum Data Set (M.D.S.) assessment, dated 11/27/20, indicated Resident B was not interviewable, per staff assessment was severely cognitively impaired, had no behaviors during the reporting period, required extensive assist of 2 staff for bed mobility and transfers, did</p>	F 0551	<p>F 551 Rights Exercised by Representative</p> <p>I. Resident B's legal representative notified DON of concern, physician was immediately notified, and medication was discontinued.</p> <p>II. Current residents residing at the facility who have been transferred to the hospital and re-admitted to the facility in the last 60 days have been identified. Their orders have been audited to ensure all medication orders are correct. Discrepancies were identified, orders clarified with physician, and legal representatives were notified.</p> <p>III. A systematic change includes all residents who have been transferred to the hospital and re-admitted to the facility will</p>	03/12/2021

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	<p>not ambulate out of his room, required total assistance for toileting and bathing, and used a wheelchair for locomotion.</p> <p>Resident B's family member and legal co-guardian was interviewed by phone on 2/24/21 at 9:45 A.M. The guardian indicated he had told both the facility, and the facility's medical director, that he did not want Resident B to receive any morphine, or any of its derivatives. He stated he had made this clear to both the medical director and the facility on "numerous occasions." He believed the medical director and the facility knew and understood his wishes, and as legal guardian, they would be followed.</p> <p>The guardian indicated he learned Resident B had received 2 doses of morphine sulfate, when a nurse called on the morning of 12/11/20 to provide an update on Resident B's condition. He stated no one from the facility had called him, or the other co-guardian, to advise them of the order for morphine sulfate, or to receive authorization for this change in treatment.</p> <p>A form from the facility's pharmacy indicated they had received a verbal order on 11/29/20 for morphine sulfate 100mg (Milligrams) per 5 ml (milliliters) 30 ml. A prescription for that medication was dated 12/02/20 and signed by the medical director. It indicated 0.5 ml (10mg) to be taken Q (every) 30 minutes PRN (as needed) for pain/dyspnea (shortness of breath)/restlessness.</p> <p>Resident B was discharged to the hospital on 11/29/20, at the guardian's request, in lieu of starting (brand name for morphine sulfate), which the guardian indicated he did not want administered. Hospital medication records indicate Resident B did not have a prescription for, and did</p>			<p>have their orders audited by the Director of Nurses and/or designee within 24 hours to ensure medication orders are correct. Any discrepancies between hospital and nursing facility medication orders will be clarified by physician and notified to legal representative before giving medications. Education will be provided to all licensed staff on re-admission orders, discrepancies, clarification to the physician, and notification to the legal representatives.</p> <p>IV. The Director of Nurses, and/or designee will review all re-admission medication orders upon return to the facility to ensure clarification from physician and notification to the legal representative has occurred. These audits will occur upon return of all re-admissions from the hospital and will continue indefinitely as a best practice. Any identified concerns from the audits will be addressed immediately.</p> <p>The results of these audits will be discussed at the facility Quality Assurance Performance Improvement meeting to ensure the deficient practice will not recur, if further education to licensed staff is needed, and if any additional action is warranted. The facility, through the QAPI program, will review, update, and make</p>

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	<p>not receive, any morphine or derivatives during his hospital stay. A hospital After Visit Summary, completed after Resident B's discharge back to the facility, contained a Current Discharge Medication List dated 12/09/20. The discharge medications did not include morphine sulfate, or any morphine derivative, or any other opioid. The resident was discharged from the hospital and returned to the facility on 12/08/20.</p> <p>A facility Controlled Drug Record documented the morphine sulfate had been administered to Resident B on 12/10/20 at 9:00 P.M., and on 12/11/20 at 5:00 A.M.</p> <p>A nursing note 12/10/2020 at 8:30 P.M., indicated "Resident is not comfortable and is appearing to be scared...Initiated first dose of MS (morphine sulfate) and (brand name for lorazepam, a sedative)..."</p> <p>A nursing note dated 12/11/2020 at 6:21 A.M., indicated "Resident SO2 (oxygen saturation) was 80's (below 90 is considered low). (brand name for lorazepam) and morphine given by mouth..."</p> <p>A timeline of events related to Resident B, received from the Director of Nursing (D.O.N.) on 2/24/21 at 1:15: P.M., contained the entries:</p> <p>"11/29/20 Received orders for (brand name for morphine sulfate) and (brand name of lorazepam). Son stated no, he wanted him (Resident B) sent to ER to be treated..."</p> <p>"12/02/20 Received written order for Morphine and (brand name of lorazepam)..."</p> <p>In interviews on 02/24/21 at 10:45 A.M., and again at 12:55 P.M., the D.O.N. stated the guardian had</p>		<p>changes to this plan of correction as needed for sustaining compliance for no less than six months.</p> <p>V. Completion Date: March 12, 2021</p>	

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	<p>not been contacted concerning the order to administer morphine sulfate, when Resident B returned from the hospital.</p> <p>The facility medical director, and Resident B's treating physician, was interviewed by phone on 02/24/21 at 11:15, with the facility owner present. The doctor indicated Resident B's guardian had made him aware that he did not want morphine, or any of its derivatives, given to Resident B. The doctor stated that the order for morphine sulfate dated 12/02/20, and the subsequent administration of 2 doses, was due to an "oversight" on his part. He noted he discontinued the medication when the D.O.N., called him and told him of the guardian's objection to the medication.</p> <p>An undated facility document, titled Resident's Rights Policy, received from the Administrator on 02/24/21 at 2:00 P.M., stated:</p> <p>"Resident rights. You have the right to a dignified existence, self-determination, and communication with and access to the persons and services inside and outside the facility.</p> <p>Exercise of rights, You have the right to exercise your rights as a resident of the facility and as a citizen or resident of the United States.</p> <p>You have a right to choose a representative to exercise your rights on your behalf.</p> <p>Your representative has the right to exercise your rights on your behalf.</p> <p>Legal guardians appointed on your behalf may exercise your rights according to Indiana law."</p> <p>This federal tag relates to Complaint IN00348079.</p>			

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	3.1-3(d)			