STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155804	A. BUILDING 00 B. WING	10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00307594 and IN00308479. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00307594 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00308479 - Substantiated. Federal/State deficiencies related to the allegations are cited at F757, F760 and F773. Survey dates: October 15, 16, 17 and 18, 2019 Facility number: 013017 Provider number: 155804 AIM number: 201237680 Census Bed Type: SNF/NF: 24 SNF: 23 Residential: 24 Total: 71 Census Payor Type: Medicare: 23 Medicaid: 13 Other: 11 Total: 47 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality Review was completed on October 25, 2019.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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 0757 SS=K Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on interview and record review, the facility failed to monitor the Vancomycin levels and follow up with residents physicians, resulting in continued multiple administrations of the medication with critically high blood levels and being admitted to the hospital with Vancomycin induced kidney failure requiring hemodialysis for 3 of 5 residents reviewed for intravenous medications. (Resident C, Resident E and Resident F) The Immediate Jeopardy began on 10/1/19, when Resident C had a high Vancomycin level the	F 0757	Past noncompliance: No POC required.	11/06/2019

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	facility was unaware of, resulting in her receiving her IV antibiotic for 8 days before being sent to the hospital with a critically high blood level and requiring hemodialysis for acute kidney failure for Vancomycin toxicity. The Administrator and the Director of Nursing were notified of the Immediate Jeopardy on 10/17/19 at 11:40 A.M. The Immediate Jeopardy was removed, and the deficient practice was corrected on 10/11/19, prior to the start of the survey and was therefore Past Noncompliance. Findings include: During an interview, on 10/15/19 at 9:46 A.M., Resident C indicated she was no longer at the facility, but had been transferred to a local hospital due to the facility giving her too much of an antibiotic. She indicated it had to do with blood work and at the hospital she had already been dialyzed twice. On 10/15/19 at 12:20 P.M., a review of the clinical record for Resident C was conducted. The record indicated the resident was admitted on 9/13/19 and sent to a local hospital on 10/10/19. The resident's diagnoses included, but were not limited to: osteomyelitis (bone infection) to left foot/ankle, cellulitis, venous insufficiency and partial amputation of left foot. An undated infection care plan indicated Resident C had osteomyelitis to her left foot and was receiving an antibiotic intravenously (IV- a therapy that delivers fluid/medication directly into a vein). The interventions included but were not limited to: administer medications as ordered, monitor for side effects/effectiveness and monitor labs per physician order. The hospital discharge orders, dated 9/13/19,			

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	indicated the resident was to have Vancomycin (antibiotic for severe infections) 750 mg (milligrams) every 12 hours and have the following lab work completed weekly: Creatinine (CR) and Vancomycin trough (measures lowest concentration of a drug and is used to guide the therapy, in the use of potentially toxic medication, which can have serious effects if therapeutic levels are exceeded.) The facility physician orders, dated 9/13/19, indicated the resident was to have the following lab work completed every Monday morning: Vancomycin trough and Creatinine levels. Lab dates were 9/16, 9/23, 9/30 and 10/7. There were no lab results for 9/16. Lab Results, dated 9/24/19, were as follows: Creatinine 0.67 (normal range 0.60-1.10) and Vancomycin 8.8 (therapeutic range of 15.0-20.0) Lab Results, dated 10/1/19, were as follows: Creatinine 1.19-high and Vancomycin trough 45.1H* (High). (10/1/19 lab results were not received or seen by the facility staff until 10/9/19) Lab Results, dated 10/8/19, were as follows: Creatinine 2.71-high and no Vancomycin trough was completed. Lab Results, dated 10/9/19, indicated the Vancomycin trough was 79.5H* (High) and on 10/10/19 Vancomycin trough was 71.6H*. A Progress Note, dated 10/9/19, indicated the trough lab work was obtained, the pharmacy and physician were notified and a new order was received. The new physician's order was to have the Vancomycin infusion discontinued and obtain			

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	a trough daily. A Progress Note, dated 10/10/19 at 4:35 P.M. indicated the following: "...This writer went into therapy gym to speak with resident about her left foot. Upon seeing resident, this writer observed resident with basin in one hand and face was flushed. Resident stated that she awoke this am with bouts of nausea/emesis. Resident stated that she had received anti-nausea medication, however, was not effective. Resident became tearful, stated that she was having concerns due to having trouble forming words from thought processes. Resident stated that she has never had this trouble before and was concerned that it was getting worse. This writer observed resident having trouble communicating her thought processes into word formation...." The note indicated the physician was notified and the resident was sent to a local emergency room. The Emergency Room Report, dated 10/10/19, indicated the resident presented with intermittent nausea, vomiting and was currently on IV Vancomycin. The report indicated her Creatinine was high at 3.93 with a high BUN at 81 (normal range 7-20). The report indicated "...the patient will be admitted for acute renal insufficiency, with pharmacy to adjust the Vancomycin based on kidney function, as well as further evaluation of the renal function...." A Nephrology Consultation, dated 10/11/19, indicated the following: " ...IMPRESSION AND RECOMMENDATION; 1. Acute kidney injury. The patient does have normal kidney function up until 9/12/19 when her Creatinine was noted to be 0.72 and now she is admitted with a Creatinine of 4 and a bicarbonate of 14. At this point, it appears to be nephrotoxic acute tubular necrosis from the			

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	use of antibiotic, especially in light of her latest Vancomycin level is about 75 mcg/mm, which is very high. At this time, all her antibiotics needs to be stopped, especially Vancomycin and we need to switch to other antibiotics. She is getting Unasyn according to her kidney function to treat her osteomyelitis, but certainly this appears to be like a Vancomycin-induced AKI [Acute Kidney Injury]. Her Vancomycin level is high at 75, and we need to repeat that later today, and then at this point, she needs to be on aggressive IV hydration to improve her kidney function ...Discussed with [physician's name] this morning and agree withholding all nephrotoxic medications, including ibuprofen and diuretic at this point..." The Hospital Physician's Progress Note, dated 10/12/19, indicated "...renal failure not improving. Patients was scheduled for a temporary dialysis catheter and will undergo a few days of hemodialysis at a higher setting to remove the Vancomycin and allow some renal recovery...." The Hospital Physician's Progress Note, dated, 10/13/19, indicated patient underwent her first round of hemodialysis yesterday without issues and is undergoing another round today. " ...Impression and Plan-Acute renal failure due to ATN [Acute Tubular Necrosis] from Vancomycin toxicity ...." A Nephrology Progress Note, dated 10/14/19, indicated " ...Acute Kidney Injury due to Vancomycin. Level was 75...and now post HD [hemodialysis] 43...." During an interview on 10/16/19 at 9:40 A.M., the Director of Nursing (DON) indicated there were no progress notes to indicate the pharmacy or the physician were notified of missed lab work for			

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	9/16/19 or the lab results obtained 10/1/19 and 10/8/19. During an interview, on 10/16/19 at 3:46 P.M., RN 2 indicated he had administered the Vancomycin on 10/1/19, but did not get the lab results, see the results and was unaware of the lab drawn completed that day. RN 2 indicated on 10/9/19, he had seen no trough results for 10/8/19, so he called the physician and asked if he could draw a trough himself and send it to the lab, which he did, and had the results within a couple hours. He also got an order to hold her Vancomycin. During an interview, on 10/16/19 at 3:59 P.M., the Assistant Director of Nursing (ADON) indicated she was usually the one retrieving the lab results off the fax machines and distributing the results to the nurses. The ADON had no explanation of why the facility did not have the Vancomycin trough results for Resident C for 10/1/19. 2. On 10/17/19 at 2:00 P.M., a review of the clinical record for Resident E was conducted. The record indicated the resident was admitted on 9/30/19 and sent to a local hospital on 10/16/19. The resident's diagnoses included, but were not limited to: infection of intervertebral disc, chronic obstructive pulmonary disease and chronic kidney disease-stage 3. An undated care plan indicated Resident E had potential for infection and fluid overload. The interventions included but were not limited to: monitor vital signs as needed, observed for increase in heart rate, congestion, shortness of breath and notify physician of any problems. The hospital discharge orders from Infectious Diseases, dated 9/27/19 indicated the resident was			

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	to have the ECF (Extended Care Facility) to calculate the Vancomycin dose. The Medication Administration Record indicated Resident E was started on Vancomycin 1 gram IV every 24 hours, on 10/1/19 and received daily through 10/9/19. The first trough level was obtained on 10/9/19, 9 days after starting the IV Vancomycin, and results were 39.9* Critical (therapeutic range 10-20). The Vancomycin was held and another trough level was obtained on 10/10/19 with a high level at 37.7. A Trough level was not obtained on 10/11/19. On 10/12/19 the trough level was 29.7H* (high). On 10/14/19 the trough level was 25.7H*. On 10/14/19 the trough level was 23.3H*. During an interview, on 10/17/19 at 2:33 P.M., the DON indicated Resident E was part of the QA (Quality Assurance) process and the first trough was ordered on 10/9/19. She indicated the facility had not followed the policy to obtain a trough prior to 4th dose, and no trough results were available on 10/11/19 due to the lab indicating "it was frozen". 10/13/19 was a Sunday and the DON indicated no labs were drawn on Sundays. The Hospital History & Physical, dated 10/16/19, indicated Resident E had recent back surgery, which resulted in an infection. The resident was admitted to a skilled nursing facility for IV antibiotics. He returns to the hospital and " ...was found to have elevated Creatinine and poor renal function and he has been admitted to the hospital for further management patient is on Vancomycin for his back infection ...." The resident's lab work indicated his BUN (Blood Urea Nitrogen) level was 56 mg/dl-high (As kidney function decreases, the BUN level increases) and the Creatinine level			

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	was high at 3.07 mg/dl-high. Nephrology was consulted and an ultrasound showed possible hydronephrosis. 3. On 10/17/19 at 10:40 A.M., a review of the clinical record for Resident F was conducted. The record indicated the resident was admitted on 9/19/19. The resident's diagnoses included but were not limited to: diabetes, heart failure, protein/calorie malnutrition, osteomyelitis of the right ankle/foot and substance dependence-in remission. A physician's order, dated 9/23/19, indicated Resident F was to have Vancomycin 1500 mg administered IV every 12 hours, and to start when medication arrived from the pharmacy. The MAR indicated the resident started receiving the Vancomycin on 9/24/19 and continued receiving the medication twice a day until 10/10/19. The resident received 31 doses of Vancomycin over 16 days before a trough level was obtained. Lab results, dated 10/9/19 issued at 4:25 P.M. indicated the trough level was high at 24.1 (range 10-20). During an interview, on 10/16/19 at 9:50 A.M., the Corporate Nurse indicated they did not have a facility policy on Vancomycin but used the facilities Nursing drug book that was kept at all the nurses stations. The facility's Nursing 2017 Drug Handbook, page 1600-1601 indicated " ...Drug-Vancomycin-Lab test monitored-Creatinine-Therapeutic ranges of test-0.5-1.7 mg/dl-Vancomycin 20-40 mcg/mL (peak)-10-20 mcg/mL (tough)-Drug levels may be checked with 3rd dose administered, at the			

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	earliest. Draw peak 1.5 to 2.5 hours after a 1-hour infusion or IV infusion is completed. Draw trough levels within 1 hour of next dose administered. Renal function can be used to adjust dosing and intervals ...." On page 1485, Adverse reactions: nausea, vomiting, diarrhea and nephrotoxicity. During an interview, on 10/16/19 at 9:07 A.M., the Director of Nursing (DON) indicated the facility did not have a policy regarding the administration of Vancomycin, however she provided their pharmacy policy titled " Vancomycin Dosing and Monitoring Protocol", undated and indicated the pharmacy policy was the one the facility used. The policy indicated " ...FACILITY RESPONSIBILITIES...If the pharmacy is to dose and/or adjust dose, the following must be done during treatment: *A Trough level must be drawn 30-60 minutes prior to each 4th dose of Vancomycin... *Based on Trough results, these guidelines should be followed *If Trough is 0-9.9, call pharmacy for dose adjustments. *If Trough is 10-20, contact pharmacy to confirm dose continuation. *If Trough is greater than 20, hold next dose and call pharmacy for dose adjustments. *Random troughs should be drawn every 24 hours until levels are less than 20 ...." The Past Noncompliance Immediate Jeopardy began on 10/1/19. The Immediate Jeopardy was removed and the deficient practice corrected on 10/11/19 when the facility implemented the following: Nursing staff in-services regarding the Policy and Procedure for Vancomycin dosing, monitoring for results and the notification of those results to the physician. In addition, lab services were contacted for additional access, so			

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	staff could obtain results and lab audits were developed with continued monitoring by the nurse managers. This Federal tag relates to complaint IN00308479. 3.1-48(a)(3) 3.1-48(a)(5)			
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure the correct IV (intravenous) antibiotic medication was administered to 1 of 5 residents reviewed for medications. (Resident C) Findings include: During an interview, on 10/15/19 at 9:46 A.M., Resident C indicated she had received someone else's antibiotic and received to much of an antibiotic while admitted to the facility. The resident was alert and oriented to person, place and time. On 10/15/19 at 12:20 P.M., a review of the clinical record for Resident C was conducted. Resident C was admitted on 9/13/19, and diagnoses included, but were not limited to: osteomyelitis to left foot/ankle, cellulitis, venous insufficiency and partial amputation of left foot. An infection care plan, undated, indicated the resident had osteomyelitis (bone infection) to her left foot and was receiving an antibiotic intravenously (IV-is a therapy that delivers fluid/medication directly into a vein). The	F 0760	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because the Sprenger Healthcare of Mishawaka agrees with the allegations and citations listed on this statement of deficiencies. Sprenger Healthcare of Mishawaka maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Sprenger Healthcare of Mishawaka written credible allegation of compliance. By submitting this plan of correction, Sprenger Healthcare of Mishawaka does not admit to the accuracy of the deficiencies. This	10/19/2019

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	interventions included, but were not limited to: administer medications as ordered, monitor for side effects/effectiveness and monitor labs per physician order. The Admission Physician's order, dated 9/13/19, indicated to give Unasyn (antibiotic) 3 grams intravenously every 6 hours for osteomyelitis. The Medication Record (MAR) for September 2019, indicated the Unasyn was administered intravenously on 9/22/19 at 12:00 A.M, 1200 P.M. and at 6:00 P.M. A Medication and Treatment incident Report, dated 9/22/19, indicated Resident C was administered the wrong IV medication, another IV antibiotic Zosyn by LPN (Licensed Practical Nurse) 4. The error was discovered by LPN 5 when she gave the next dose of Resident C's IV Unasyn. The report indicated LPN 5 observed a bag of Zosyn 3.375 grams/50 milliliter with Resident F's name on it, in Resident C's room, on the IV pole. The report indicated '...Error occurred, reached resident, no harm...." During an interview, on 10/16/19 at 3:20 P.M., the Director of Nursing (DON) indicated she was aware of the medication error which occurred when resident C received Resident F's antibiotic, and they had notified the physician. She indicated Resident F had received the correct medication. On 10/18/19 at 9:30 A.M., the Administrator provided a policy title, "Medication Administration Protocol", dated 10/15, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Medications are administered to the right resident, the right dose, right time, right drug, right route,		plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Sprenger Healthcare of Mishawaka reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding. Completion dates are listed within the POC. In accordance with F760, Section 483.45(f)(2), Residents are free of Significant Med Errors, related to the allegation that the facility failed to ensure the correct IV medication was administered. This affected Resident C, and there were no negative outcomes as a result of this allegation. Resident C, no longer resides at the facility. For all other Residents, all licensed nurses were educated on the facility's "Medication Administration Protocol". Education was conducted on 10/11/2019. The DON or Designee, will conduct audits to ensure Medications are administered per the "Medication Administration Protocol". Audits will be conducted on 3-4 residents per week, for 4 weeks and then randomly thereafter for a total of 4 months. Results of the audits to be reviewed by QA committee.	

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	and right documentation...10. Any errors should be report to the DON, physician and resident/POA [Power of Attorney]...." This Federal tag relates to complaint IN00308479. 3.1-48(a)(1)			
F 0773 SS=D Bldg. 00	483.50(a)(2)(i)(ii) Lab Srvcs Physician Order/Notify of Results §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Based on interview and record review, the facility failed to ensure laboratory results were received and acted upon, the attending physician was notified of abnormal results and results were a part of the residents clinical record, for 3 of 5 residents reviewed for laboratory work. (Resident C, Resident E and Resident F). Findings include: 1. On 10/15/19 at 12:20 P.M., a review of the clinical record for Resident C was conducted. The record indicated the resident was admitted on 9/13/19 and sent to a local hospital on 10/10/19. The resident's diagnoses included, but were not limited to: osteomyelitis to left foot/ankle,	F 0773	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because the Sprenger Healthcare of Mishawaka agrees with the allegations and citations listed on this statement of deficiencies. Sprenger Healthcare of Mishawaka maintains that the alleged deficiencies do not, individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan	10/19/2019

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	155804	A. BUILDING 00 B. WING	10/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SPRENGER HEALTH CARE OF MISHAWAKA	60257 BODNAR BLVD MISHAWAKA, IN 46544

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	cellulitis, venous insufficiency and partial amputation of left foot. An infection care plan, undated, indicated the resident had osteomyelitis (bone infection) to her left foot and was receiving an antibiotic intravenously (IV-is a therapy that delivers fluid/medication directly into a vein). The interventions included but were not limited to: administer medications as ordered, monitor for side effects/effectiveness and monitor labs per physician order. The hospital discharge orders, dated 9/13/19, indicated Resident C was to be administered Vancomycin 750 mg (milligrams) IV every 12 hours and have the following lab work completed weekly: Creatinine (CR) and Vancomycin trough (measures lowest concentration of a drug and is used to guide the therapy, in the use of potentially toxic medication, which can have serious effects if therapeutic levels are exceeded.) The facility physician orders, dated 9/13/19, indicated the resident was to have the following lab work completed every Monday morning: Vancomycin trough and Creatinine levels. Lab dates were 9/16, 9/23, 9/30 and 10/7. There were no lab results for 9/16. Lab Results, dated 9/24/19, were as follows: Creatinine 0.67 (normal range 0.60-1.10) and Vancomycin 8.8 (therapeutic range of 15.0-20.0) Lab Results, dated 10/1/19, were as follows: Creatinine 1.19-high and Vancomycin trough 45.1H* (High) Lab Results, dated 10/8/19, were as follows:		of correction shall operate as Sprenger Healthcare of Mishawaka written credible allegation of compliance. By submitting this plan of correction, Sprenger Healthcare of Mishawaka does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Sprenger Healthcare of Mishawaka reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action, or proceeding. Completion dates are listed within the POC. In accordance with F773, Section 483.50(a)(2)(i)(ii), Lab Srvcs Physician Order/Notify of Results, related to the allegation that the facility failed to ensure laboratory results were received and acted upon and that the attending physician was notified of abnormal results were a part of the clinical record. This affected Resident C, E and F and there were no negative outcomes as a result of this allegation. Resident C, Resident E and Resident F no longer reside at the facility. For all other residents, the facility conducted education with all licensed nurses to ensure that all laboratory results are reported to the physician and acted upon as	

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	Creatinine 2.71-high and no Vancomycin trough was completed. Lab Results, dated 10/9/19, indicated the Vancomycin trough was 79.5H* (High) and on 10/10/19 Vancomycin trough was 71.6H*. A Progress Note, dated 10/9/19, indicated the trough lab work was obtained, the pharmacy and physician were notified and a new order was received. The new physician's order were to have the vancomycin infusion discontinued and obtain a trough daily. During an interview, on 10/16/19 at 9:40 A.M., the Director of Nursing (DON) indicated there was no progress notes indicating the pharmacy nor the physician was notified of missed lab work for 9/16/19 or the lab results obtained 10/1/19 and 10/8/19. During an interview, on 10/16/19 at 3:46 P.M., RN 2 indicated he worked 10/1/19, but he was unaware of labs being done on Resident C that day and did not get the results of Resident C's labs. On the 9th of October, RN 2 indicated he had known there were to be lab results for the 8th but none were located in her record, so he called the physician and asked if he could draw the blood himself and send it to lab, which he completed and had the results within a couple hours and the Vancomycin trough level was very high. He contacted the physician and received an order to hold the medication and do another trough level the next day. During an interview, on 10/16/19 at 3:59 P.M., the Assistant Director of Nursing (ADON) indicated she usually is the one retrieving the lab results off the fax machines and/or lab website and		needed. Education was conducted on 10/15/2019. Audits will be conducted on 3-4 Residents for 4 weeks and then randomly thereafter for a total of 4 months, to ensure laboratory results are being reported to the physician and are acted upon as needed. Results of the audits to be reviewed by QA committee.	

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	distributing the results to the nurses, but could not explain why the facility never received the lab results for Resident C for 10/1/19. 2. On 10/17/19 at 2:00 P.M., a review of the clinical record for Resident E was conducted. The record indicated the resident was admitted on 9/30/19 and sent to a local hospital on 10/16/19. The resident's diagnoses included, but were not limited to: infection of intervertebral disc, chronic obstructive pulmonary disease and chronic kidney disease-stage 3. The hospital discharge orders from Infectious Diseases, dated 9/27/19, indicated the resident was to have the ECF (Extended Care Facility) to calculate the vancomycin dose. The Medication Administration Record indicated the resident was started on vancomycin 1 gram IV every 24 hours. The medication was started, on 10/1/19 and the resident received the medication daily through 10/9/19. The first laboratory trough level was obtained 9 days later, on 10/9/19, and results were 39.9 Critical (range 10-20). During an interview, on 10/17/19 at 2:33 P.M., the DON indicated Resident E was part of the QA (Quality Assurance) process and the first trough was ordered on 10/9/19. She indicated the facility had not followed the pharmacy/facility policy, to obtain a trough prior to 4th dose. 3. On 10/17/19 at 10:40 A.M., a review of the clinical record for Resident F was conducted. The record indicated the resident was admitted on 9/19/19. The resident's diagnoses included but were not limited to: diabetes, heart failure,			

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	protein/calorie malnutrition, osteomyelitis of the right ankle/foot and substance dependence-in remission. A physician's order, dated 9/23/19, indicated resident was to be administered Vancomycin IV-1500 mg every 12 hours, to start when the medication arrives from the pharmacy. The MAR indicated Resident F started receiving IV Vancomycin on 9/24/19 and continued receiving the medication twice a day until 10/10/19. The resident received 31 doses of Vancomycin over 16 days before a trough level was obtained. Lab results, dated 10/9/19 issued at 4:25 P.M. indicated the trough level was high at 24.1 (range 10-20). During an interview, on 10/16/19 at 9:50 A.M., the Corporate Nurse indicated they did not have a facility policy on Vancomycin but used the facilities Nursing drug book that was kept at all the nurses stations. The facility's Nursing 2017 Drug Handbook, page 1600-1601 indicated " ...Drug-Vancomycin-Lab test monitored-Creatine-Therapeutic ranges of test-0.5-1.7 mg/dL-Vancomycin 20-40 mcg/mL (peak)-10-20 mcg/mL (tough)-Drug levels may be checked with 3rd dose administered, at the earliest. Draw peak 1.5 to 2.5 hours after a 1-hour infusion or IV infusion is completed. Draw trough levels within 1 hour of next dose administered. Renal function can be used to adjust dosing and intervals ...." On page 1485, Adverse reactions: nausea, vomiting, diarrhea and nephrotoxicity. During an interview, on 10/16/19 at 9:07 A.M., the Director of Nursing (DON) indicated the facility			

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	did not have a policy regarding the administration of vancomycin, however she provided their pharmacy policy titled " Vancomycin Dosing and Monitoring Protocol", undated and indicated the pharmacy policy was the one the facility used. The policy indicated " ...FACILITY RESPONSIBILITIES...If the pharmacy is to dose and/or adjust dose, the following must be done during treatment: *A Trough level must be drawn 30-60 minutes prior to each 4th dose of Vancomycin... *Based on Trough results, these guidelines should be followed *If Trough is 0-9.9, call pharmacy for dose adjustments. *If Trough is 10-20, contact pharmacy to confirm dose continuation. *If Trough is greater than 20, hold next dose and call pharmacy for dose adjustments. *Random troughs should be drawn every 24 hours until levels are less than 20 *Due to liability, if more than six does of Vancomycin have been administered without a Trough level being obtained, pharmacy may refuse to send further doses, until a Trough is drawn and reported...." This Federal tag relates to complaint IN00308479. 3.1-49(a) 3.1-49(f)(2) 3.1-49(f)(4)			