DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	570617	A. BUILDING: _____ B. WING _____	C 09/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERITUS AT SILVER PINES	136 36TH AVENUE SW CEDAR RAPIDS, IA 52404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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) COMPLETE DATE
R 000	Initial Comments No deficiencies were cited regarding Complaints #45118 and #44412. The following deficiencies were cited regarding Incidents #44877 and #44824:	R 000		
R 103	57.10(2)a Administration 481-- 57.10(135C) Administration 57.10(2) The administrator shall: a. Be responsible for the selection and direction of competent personnel who provide services for the resident care program. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the Administrator failed to ensure all staff members were competent in nursing policies and procedures regarding resident medications. Findings include: 1. On 7/22/13 it was discovered that a 30 count bottle of Diazepam for Resident #1 could not be located. The following is a timeline of events based on interviews conducted with the Administrator on 8/29/13 at 2 PM, the DON (Director of Nursing) on 9/4/13 at 12:40 PM, Staff E on 9/4/13 at 1:35 PM, Staff C on 8/29/13 at 3 PM as well as a review of Medication Administration Records (MARs) and the facility's internal investigation: 7/19/13 - The pharmacy arrived at the facility to	R 103		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 103	Continued From page 1	R 103		

deliver a paper bag of medications for Resident #1. (Documentation from the pharmacy provided to the surveyor revealed the medications were Diazepam (valium) and Tramadol). At the time the pharmacy arrived, the DON was leaving for an appointment. The DON signed for the bag of medications, but did not look in the bag to verify what medications were in it. The DON handed the bag to Staff E, who was not qualified to pass or handle medications, with the instructions to give the bag to the nurse on duty (Staff F) who was in the back area of the facility.

a. Staff E confirmed during interview that she recalled receiving medications from the DON but was unsure whose name was on the bag. She took the bag and gave it to Staff F.
b. A review of a document written for the facility by Staff F dated 7/25/13 revealed she "kinda remember getting something from somebody in the back hallway." She remembered putting the information sheets from the pharmacy in a plastic bag with the pill bottles, then putting the bag in a drawer. She thought there were two pill bottles but couldn't be sure because "my memory is so foggy."

7/20/13 - The AM nurse, Staff C administered Resident #1's Diazepam which was ordered to be given once daily in the morning. The medication was still available and the new pill bottle was not needed yet.

7/21/13 - The AM nurse, Staff A administered Resident #1's Diazepam.

7/22/13 - The AM nurse, Staff A circled 7/22/13 on the MAR and documented she could not administer the Diazepam because it was not available. There was no documentation to

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 103	Continued From page 2 indicate the staff member attempted to order more or that she notified the DON of the unavailability of the medication. 7/23/13 - The AM nurse, Staff C circled 7/23/13 on the MAR and documented that he could not administer the Diazepam because it was not available. There was no documentation to indicate the staff member attempted to order more or that he notified the DON of the unavailability of the medication. a. When interviewed, Staff C stated he had tried to call an order in for the Diazepam using the pharmacy's automated system. Staff C stated he did not document this. 7/24/13 - Staff C noted there was still no Diazepam for Resident #1 so he called the pharmacist about the medication he had ordered on the automated system to ask why it had not been delivered. The pharmacist informed Staff C that a 30 count bottle of Diazepam had been delivered to the facility on 7/19/13 and so it could not be ordered again. Staff C notified the Administrator that the bottle of Diazepam that was delivered on 7/19/13 could not be found. The paper bag containing Tramadol was located in the drawer where Staff F put it, but there was no Diazepam in the bag. 7/25/13 - The pharmacy notified the facility that if they wanted to order a new bottle of Diazepam (paid for by the facility), the facility would need to obtain a new prescription for the medication. The facility contacted the resident's physician and informed him that a new prescription needed to be faxed to the pharmacy to allow the resident to obtain his/her medications.	R 103		

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 103	Continued From page 3 7/26/13 - The pharmacy contacted the facility to inform them that the prescription had not been faxed from the physician yet. 7/29/13 - The facility finally received a replacement bottle of medications for Resident #1. 2. Between the day the Diazepam was delivered (7/19/13) and the date it was discovered missing (7/22/13), 6 different staff had access to the medications. On the day that the medications arrived (7/19/13), no one checked to see if the pharmacy had the correct medications in the bag that was delivered. 3. It could not be determined what happened to the bottle of Diazepam. 4. A review of facility policies and procedures revealed the following policy: Number G-1, Medication Management: Receiving Medications: "The community staff will verify the receipt of the correct medications as ordered upon delivery from the pharmacy; any discrepancies in the order should be noted on the delivery manifest. If there is a discrepancy, the pharmacy should be notified immediately, so that corrective measures can be taken."	R 103		
R 146	57.12(2)d Personnel 481 - 57.12(135C) Personnel. 57.12(2) Supervision and staffing. d. Physician's orders shall be implemented by qualified personnel.	R 146		

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 146	Continued From page 4	R 146		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and resident record review, the facility failed to follow the physician's orders for 1 of 5 residents reviewed (Resident #3). The facility reported a census of 50 residents. Findings include:

A review of Resident #3's record revealed an admission date of 8/26/11. The Physician's Orders dated 7/17/2013 identified diagnosis of Alzheimer's disease, depressive disorder, small cell lung cancer and chronic hypoxemia (low level of oxygen level in the blood).

A review of incident reports revealed an incident on 2/16/13 where Resident #3 choked on ham during a meal in the dining room. Staff administered the Heimlich Maneuver and effectively removed the piece of ham. On 3/15/13, the physician ordered a Dysphasia III diet (soft/tender food or mechanical soft/ground food) which was implemented for Resident #3.

The Service Notes dated 7/28/2013 at 11:45 a.m. reflected Resident #1 sat in the dining room eating dinner. The resident began vomiting the meal. The resident's oxygen saturation was 94 percent (normal range 95-100 percent), respirations 22 (normal rate is 16-20) and temperature 98.4 Fahrenheit (normal 98.6). The staff took the resident to her/his room.

According to an incident report dated 7/28/13, Resident #3 choked on a piece of roast beef (from a general diet plate) that was given to him/her by Staff B. The resident was able to

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R 146	Continued From page 5	R 146		

breathe after choking but began to spit up large amounts of thick mucus.

The Service Notes dated 7/28/2013 at 1:30 p.m. revealed the resident requested assistance. The resident's blood pressure measured 155/96, respirations 26, pulse 69 and temperature 99.4 Fahrenheit. The resident's oxygen saturation level registered at 92 percent and started dropping to 89 percent. The nurse had the resident transferred to the hospital via ambulance at 2:15 p.m.

The hospital records reflected the resident was taken to the operating room from the ER (Emergency Room) and given anesthesia in order to remove the beef with an endoscopy procedure. The resident remained hospitalized for observation to manage the hypoxia. The physician documented the resident had chronic respiratory failure that had been exacerbated by the foreign body (beef) and the required anesthesia [required to remove the roast beef]. The resident required observation and supplemental oxygen therapy and discharge on 7/30/2013.

The Service Notes dated 7/30/2013 at 1:10 p.m. reflected the resident returned to the facility on 7/30/2013 at 11:00 a.m.

On 9/4/13 at 12:40 PM, the DON stated Staff B originally had the appropriate meal (ground chicken) in her hand to give Resident #3, but the resident said he/she did not order chicken and wanted the roast beef. Staff B stated to the administrator afterwards that he/she automatically grabbed a roast beef plate and gave it to the resident, instead of slowing down to think about the diet order for "mechanical soft." Staff B told

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 146	Continued From page 6 the DON that he/she knew what Resident #3's diet was, but had been busy and made a mistake. On 8/29/13 at 2 PM, the Administrator stated the facility followed up the incident with dietary training for all staff members and new procedures for checking special diets at each meal.	R 146		
R 274	57.19(3)g Drugs 481--57.19(135C) Drugs. 57.19(3) Drug administration g. Unless the unit dose system is used, the person assigned the responsibility of medication administration must complete the procedure by personally preparing the dose, observing the actual act of swallowing the oral medication, and charting the medication. In facilities where the unit dose system is used, the person assigned the responsibility must complete the procedure by observing the actual act of swallowing the medication and charting the medication. Medications shall be prepared on the same shift of the same day that they are administered, unless the unit dose system is used. This REQUIREMENT is not met as evidenced by: Based on staff interview and resident record review, the facility failed to document all medications administered for 2 out of 5 residents reviewed (Resident #4 & Resident #5). Findings include:	R 274		

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 274	Continued From page 7 1. A review of Resident #4's record revealed an admission date of 1/24/11. Upon reviewing the medication administration records for Resident #4 in July of 2013, the following gaps in the record were discovered: - 7/14/13 Horizant 600mg tab ER (ordered for three times a day) was only documented as being given twice on the 14th. - 7/11/13 Ropinirole HCL 1 mg (ordered for three times a day) was only documented as being given twice on the 11th. - 7/28/13 Isosorbide Dinitrate 10 mg (ordered for four times a day) was only documented as being given three times on the 28th. - 7/15/13 Montelukast Sodium F/C 10 mg (ordered for once a day before bed), Ropinirole HCL 2 mg (ordered for once a day before bed), and Trazedone HCL 100 mg (ordered for once a day before bed) were not documented as given. 2. A review of Resident #5's record revealed an admission date of 1/24/11. Upon reviewing the medication administration records for Resident #4 in the month of April 2013, the following gaps in the record were discovered: - Resident #5's order for 90 cc's of Ensure Supplement (ordered for three times a day) was only documented as being given twice on 4/1/13, 4/2/13, 4/5/13, 4/6/13, 4/9/13, 4/10/13, 4/12/13, 4/16/13, 4/19/13, 4/23/13, 4/26/13, 4/27/13 and 4/28/13. The Ensure was documented as only being given once on 4/4/13 and 4/7/13. The Ensure was not documented as given at all on 4/8/13 and 4/11/13. 3. On 9/4/13 at 2 PM, the administrator confirmed the above findings.	R 274		

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 343	Continued From page 8	R 343		
R 343	57.22(2) Service plan 481--57.22(135C) - Service plan. 57.22(2) Within 30 days of admission, the administrator or the administrator ' s designee shall, in conjunction with the resident, other facility staff or any organization that works with or serves the resident, develop a written, individualized, and integrated program of ongoing services for the resident. a. The program shall be planned and implemented to address the resident ' s priorities and assessed needs, such as living, rehabilitation, activity, behavioral, emotional, mental health and social, and shall take into consideration the resident ' s personal goals and preferences, including the resident ' s preferred living situation. b. The service plan shall include specific goals and objectives with regular documentation of each. c. The service plan shall be reviewed at least quarterly, or more often as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to implement the nutrition/eating service plan for 1 of 5 residents reviewed (Resident #3). The facility reported a census of 50 residents. Resident #3 required a dysphagia (mechanical soft) diet as identified in the Individualized Service Plan. The resident did not receive the appropriate diet and choked. The	R 343		

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 343	Continued From page 9	R 343		

resident required removal of the food bolus manually under anesthesia and hospitalization. Findings include:

A review of Resident #3's record revealed an admission date of 8/26/11. The Physician's Orders dated 7/17/2013 identified diagnosis of Alzheimer's disease, depressive disorder, small cell lung cancer and chronic hypoxemia (low level of oxygen level in the blood).

A review of incident reports revealed an incident on 2/16/13 where Resident #3 choked on ham during a meal in the dining room. Staff administered the Heimlich Maneuver and effectively removed the piece of ham. On 3/15/13, the physician ordered a Dysphasia III diet (soft/tender food or mechanical soft/ground food) which was implemented for Resident #3.

The Individualized Service Plan dated 4/5/2013 identified the resident had a problem with nutrition/eating and needed a mechanical soft-ground diet.

According to an incident report dated 7/28/13, Resident #3 choked on a piece of roast beef (from a general diet plate) that was given to him/her by Staff B. The resident was able to breathe after choking but began to spit up large amounts of thick mucus.

The Service Notes dated 7/28/2013 at 1:30 p.m. revealed the resident requested assistance. The resident's blood pressure measured 155/96, respirations 26, pulse 69 and temperature 99.4 Fahrenheit. The resident's oxygen saturation level registered at 92 percent and started dropping to 89 percent. The nurse had the resident transferred to the hospital via ambulance at 2:15

DEPARTMENT OF INSPECTIONS AND APPEALS

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R 343	Continued From page 10 p.m. On 9/4/13 at 12:40 PM, the DON stated Staff B originally had the appropriate meal (ground chicken) in her hand to give Resident #3, but the resident said he/she did not order chicken and wanted the roast beef. Staff B stated to the administrator afterwards that he/she automatically grabbed a roast beef plate and gave it to the resident, instead of slowing down to think about the diet order for "mechanical soft." Staff B told the DON that he/she knew what Resident #3's diet was, but had been busy and made a mistake. On 8/29/13 at 2 PM, the Administrator stated the facility followed up the incident with dietary training for all staff members and new procedures for checking special diets at each meal.	R 343		

R 103 -57.10(2)a Administration- In order to meet the intent of R103 for the facility to be in compliance (to have competent personnel to provide services for the resident care program) the following have been put in to place:

The ED has contracted with a different staffing agency.

The narcotic count is being checked daily by the ED/ designee.

A revised orientation program for contracted agency staff has been implemented.

For medication management (#G-1) Education has been provided for licensed nurses and med aides on 10/29/13.

In order to maintain and monitor the medication management system for compliance the orientation program for agency staff as well as the facility staff will identify the 3 medication areas specified in this survey process. This was in-serviced at a nurse's meeting on 10/29/2013.

The ED/ Designee will be responsible for ensuring all new agency staff receives the revised orientation upon hire.

Monthly review of the medication management process will be on the agenda of the CQI meetings for 3 months to review for compliance in the area of med administration and as needed thereafter.

Completion Date: 10/30/2013

R146 57.12(2)d Personnel – In order to meet the intent of R146 and for the community to be in compliance (to have competent personnel to provide services for the resident care program) the following have been put in to place:

This facility has presented a class on medication administration which involved following Dr.'s orders on 10/29/2013. RNs, LPNs and Medication Aides received this education and hand outs were provided for reference.

Additional education has been provided to all staff on the service plans on 8/29/2013 and was re-in-serviced on 10/29/13. A sign in sheet identifies staff in attendanec.

11/4/13 DD 11/4/13

R146 57.12(2)d Personnel (cont.)

Nursing assessment and following Dr.'s orders and delegation/supervision of staff was re-in-serviced with the nurses at the 10/29/2013.

The persons responsible to check Dr.'s orders are the Resident Care Director/designee on a monthly and as needed. This was re-initiated in June 2013.

The ED/Resident Care Director/Dietary Services Manager are monitoring dietary staff for the accuracy of receiving special diets.

The Resident Care Director/Designee will continue to monitor and provide additional education for the nurses as needed for nursing staff to stay in compliance for following Dr.'s orders. Audits are being done by the Resident Care Director and Dietary Services Manager and will continue monthly for 3 months and as needed thereafter to remain in compliance.

F146 will be placed on the CQI meeting agenda monthly program for 3 months to assess the continued compliance and performance.

Completion Date: 10/30/2013

R274 57.19(3)g Drugs- In order to meet the intent of R 2749 to make sure medication is documented when administered) the following have been put into place:

The nursing staff responsible for medication administration attended a medication administration class on 10/29/2013

Med pass will be monitored as needed by the Resident Care Director. Nursing staff responsible for medication administration will follow the 6 Rights of medication administration and be held accountable in performance and procedure. Resident Care Director/designee will provide counseling and education for staff until performance is acceptable.

Resident Care Director/ Designee will complete weekly audits of the medication administration record and be responsible to maintain proper documentation.

R274 will be placed on the monthly agenda of CQI program for 3 months and performance of medication documentation will be addressed for continued compliance.

Completion Date: 10/30/2013

R 343 57.22(2) Service Plan – In order to meet the intent of R343 and for the facility to be in compliance (To have the facility implement correct nutritional service plans) the following have been put into place:

The dietary staff was re-in-serviced on 8/29/13 on specialty diets for the residents to receive at each meal.

Monthly audits will continue to be completed by the Dietary Services Manager.

Nursing staff were re-in-serviced at a meeting on 8/29/13 regarding following the Dr.'s orders for special diets. The Resident Care Director/Designee/Dietary Service Manager will be responsible for ensuring the Dr.'s orders for special diets are followed.

The CNA that did not provide the correct diet to the resident was terminated.

In order to monitor and ensure that specialty diets are followed, the Resident Care Director and Dietary Services Manager will do audits monthly and as needed.

To maintain compliance with R343, the plan of correction will be added to the monthly meeting agenda of CQI program for 3 months to address and assess for continued compliance.

Completion Date: 10/30/2013

Julie Bevans
LPN RCD