

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

PRINTED: 06/01/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525708	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/19/2015
NAME OF PROVIDER OR SUPPLIER WI VETERANS HOME AT CHIPPEWA FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2175 E PARK AVE CHIPPEWA FALLS, WI 54729		
(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) COMPLETION DATE	
F 000	INITIAL COMMENTS This was a complaint survey conducted at Wisconsin Veterans Home at Chippewa Falls on 05/19/15. # of federal citations issued: 1 The most serious citation is F425 at a scope/severity level of D (isolated, actual harm with potential for more than minimal harm). Census: 71 Sample size: 6 Survey Coordinator: 31086	F 000			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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. 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. 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.	F 425			

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 425	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility did not have an effective process to receive and administer medications from the pharmacy in a timely manner.</p> <p>Resident #2 did not receive an antianxiety medication in a timely manner when displaying symptoms of agitation.</p> <p>This is evidenced by:</p> <p>Resident #2's diagnoses included traumatic right intertrochanteric hip fracture, thrombocytopenia, anemia, severe dementia, atrial fibrillation and pain. He was admitted to the facility for pain management with hospice referral.</p> <p>On 05/19/15, Surveyor 30754 reviewed Resident #2's clinical record. The record indicated that Resident #2 was admitted to the facility on 05/15/15 at 2:00 p.m., for comfort cares. Hospice was consulted. Orders present on admission included: Morphine (a narcotic pain medication) 10 mg (milligrams) to be given every hour as needed for pain. Ativan (an antianxiety medication used to treat agitation) 2 mg to be given every one hour as needed for agitation.</p> <p>On 05/15/15 at 6:00 p.m., the resident's behaviors included pulling at his catheter, causing trauma to the site, which resulted in blood being present in the catheter tubing and at the penile shaft. Upon interview, Registered Nurse (RN) A stated the resident was agitated, flailing, pulling at his catheter and yelling in pain. The facility staff contacted the resident's son to come to the</p>	F 425			

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F 425	<p>Continued From page 2</p> <p>facility to provide 1:1 supervision to the resident in the hopes that this would assist in calming the resident.</p> <p>RN A contacted the physician on call and an order was given to increase the as needed morphine to 10 mg every 30 minutes. RN A stated the increased dose of Morphine was given when the order was obtained, and given as ordered. RN A stated Resident #2 still displayed anxiety which the increased Morphine dose did not control.</p> <p>RN A contacted the pharmacy to gain permission to obtain the physician ordered Ativan from the facility's emergency contingency box. RN A spoke with the on-call pharmacist, whose name she could not remember. The pharmacist stated, "Do not take the Ativan from the pharmacy contingency box since the ordered doses would be en route to the facility." When RN A asked why the medication could not be obtained from the emergency box at the facility, the pharmacist stated, "The resident has already been billed for the maximum amount of Ativan allowed, which is packaged and en route to the facility."</p> <p>The documentation, timed at 8:17 p.m., stated: "Pharmacy called at 7:00 p.m. to get (sic) ordered lorazepam (Ativan). Called three more times and they (the pharmacy) stated they would bring the drug and stop first at this facility. This was over an hour ago. Pharmacy called back again and the truck has not yet left the pharmacy." RN A stated that when the medication did not arrive by 8:17 p.m., and the increased Morphine dose was ineffective, RN A decided to send the resident back to the hospital for pain control. RN A spoke with the Power of Attorney (POA) who stated he did not want the resident to be transferred back to</p>	F 425			

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F 425	<p>Continued From page 3</p> <p>the hospital. RN A attempted to contact the Director of Nursing (DON). RN A was not able to establish contact with the DON. RN A then called the administrator who did not know what to do.</p> <p>RN A stated the resident remained in the facility. The documentation further stated, "Ativan 2 mg. given at 9:40 p.m. when it arrived from the pharmacy." Upon interview with Surveyor 30754, RN A confirmed the Ativan was given at that time (9:40 p.m.).</p> <p>Surveyor 30754 interviewed the Nursing Home Administrator (NHA). The NHA stated that RN A contacted her on 05/15/15. The NHA stated, "When I talked to the nurse, we talked about the resident needing 1:1 because of anxiety. He had the Morphine. RN A said she called the pharmacy to get it (the Ativan) out of contingency. The pharmacy said they refused to give RN A an authorization # (to remove the medication from the emergency box) because it was coming. RN A did not send Resident #2 to the hospital because the medication was en route."</p> <p>Surveyor 30754 interviewed the DON and RN B, who were present when the resident was admitted. RN B stated the resident was in pain upon arrival, and received as needed Morphine. Surveyor 30754 asked the DON and RN B to explain the procedure for obtaining as needed medications from the emergency contingency box. The DON stated that if a medication is needed, the staff contact the pharmacy, who issues an authorization number. After confirming the authorization number (which confirms the order is on file at the pharmacy), the staff record the number on the contingency sign out sheet, remove the medication from the box, and after</p>	F 425			

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F 425	<p>Continued From page 4</p> <p>counting the remaining medication, administer the medication to the resident.</p> <p>Surveyor 30754 asked the DON and RN B to explain what would happen if a resident needed medication and the staff was unable to obtain an authorization number from the pharmacy, and the medication was in the contingency box. RN B stated, "That would not be a reason not to administer the medication. I have never had that problem, but that would be no reason for someone to be in pain." The DON nodded. The DON stated that she was on call 24/7 if problems occurred with this system.</p> <p>Surveyor 30754 contacted the pharmacy. Pharmacist F told Surveyor 30754 the pharmacy requires authorization numbers prior to allowing the facility staff to remove an item from the contingency box.</p> <p>Surveyor 30754 interviewed RN C, who functions as the facility's unit manager on the p.m. shift. RN C confirmed that the facility practice is to contact the DON if problems or questions arise. RN C was not present on 05/15/15. The DON told Surveyor 30754 that when the p.m. unit manager is not working, the charge nurse functions as the p.m. supervisor.</p> <p>Surveyor 30754 reviewed two documents entitled "Shipment Details." The documents list the resident's name and indicate that 30 Ativan 0.5 mg tablets and Ativan 2.0 mg. intensol 2 mg/ml 30 ml were delivered to the facility by the pharmacy delivery truck. One document says "Local status: Delivered. Last status on: 05/15/15 9:24 p.m." The other document says: "Local status: Delivered. Last status on: 05/15/15 9:24</p>	F 425			

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F 425	Continued From page 5 p.m." The DON and the NHA were notified of the above concerns on 05/19/15.	F 425		