| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155546 | | 02/03/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BETHEL POINTE HEALTH AND REHAB | 3400 W COMMUNITY DR<br>MUNCIE, IN 47304 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaint IN00192403.<br><br>Complaint IN00192403 - Substantiated. Federal/State deficiencies related to allegations are cited at F281 and F333.<br><br>Survey date: February 2 and 3, 2016<br><br>Facility number: 000565<br>Provider number: 155546<br>AIM number: 100267630<br><br>Census bed type:<br>SNF: 14<br>SNF/NF: 77<br>Total: 91<br><br>Census payor type:<br>Medicare: 14<br>Medicaid: 57<br>Other: 20<br>Total: 91<br><br>Sample: 4<br><br>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.<br><br>QR completed by 11474 on February 8, | F 0000 | The following Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. Submission of the 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. This facility respectfully requests paper compliance for the deficiencies cited. | |

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 determined that other safegaurds 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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| | 2016. | | | |
| F 0281<br>SS=D<br>Bldg. 00 | 483.20(k)(3)(i)<br>SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br>The services provided or arranged by the facility must meet professional standards of quality.<br>Based on record review and interview, the facility failed to ensure residents were provided patient care in accordance with acceptable professional standards for 1 of 4 residents who were reviewed for medication administration. (Resident C)<br><br>Findings include:<br><br>The clinical record of Resident C was reviewed on 2/2/16 at 2:43 p.m. Diagnoses included, but were not limited to, hypertension, diabetes type 2, dementia, atrial fibrillation, chronic heart failure and acute cholecystitis.<br><br>Review of the nursing notes, dated 1/27/16, indicated Resident C had received the following medications intended for another resident at 7:30 p.m.:<br>Carbidopa-Levadopa(antiparkinsons) 25-100 mg, Olanzapine (antipsychotic) 20 mg, gabapentin (anticonvulsant) 300 mg, docusate (laxative) 100 mg, | F 0281 | Resident C's physician was immediately notified and resident was monitored for severe sedation, confusion or abnormal bleeding per MD instruction. There were no other residents affected, as of the results of our investigation found the orientee did not administer medications without direct supervision of her preceptor except for this one incident. RN #5, LPN #6 and orientee were counseled and received one-on-one in-servicing on facility Medication Administration Policy. RN #5, LPN #6 and orientee each provided return demonstration on correct procedure of medication administration to a Nurse Manager. A shift-to-shift in-service was immediately placed for nurses/QMA's on facility Medication Administration Policy. Medication Administration Policy was added to facility nursing orientation packet. Nurse Managers will complete medication administration skill checks with new orientees upon hire. DON/Designee completed | 02/04/2016 |

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| | haloperidol (antipsychotic) 10 mg and Diazepam (anticonvulsant) 2 mg. The physician was notified and ordered Resident C to be monitored and sent to the hospital for any symptoms and severe sedation, confusion, or abnormal bleeding.<br><br>During an interview on 2/3/16 at 3:00 p.m., LPN #6 indicated she had asked another nurse to administer medication to Resident D on the skilled care unit. LPN #6 indicated she had pre-set the medications and gave them to the other nurse to administer to Resident D. "I know I'm not supposed to but I pre-set his (Resident D) meds (medications) and gave them to (RN #5) to give."<br><br>During an interview on 2/3/16 at 2:50 p.m., RN #5 indicated she had received pre-set medications for Resident D from LPN #6. "I popped his (Resident C) meds to give it to him. Another resident distracted me and I handed his (Resident C) meds to the orientee. I gave her the wrong meds. I had another resident's medications because I was passing his (Resident D) meds for another nurse. We aren't supposed to pre-set meds and I never do. Guess it was some bad decisions. I know I'm not supposed to give meds pulled by another nurse, but I was just trying to help out." RN #5 | | medication administration skill checks with nurses/QMA's. DON/Designee will complete medication administration skill checks with 3 nurses/QMA's every 4 months, on-going to ensure acceptable professional standards were provided. Results of these audits will be forwarded to QA for review monthly X3 then quarterly. | |

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| | indicated she was going to watch the orientee give the medications to Resident C, but the orientee had given the medications by the time she arrived to the resident's room.<br><br>During an interview on 2/3/16 at 3:05 p.m., the DON (Director of Nursing) indicated the medication error had been reported and investigated. The investigation report was provided for review at this time. The report indicated Resident C had been given the wrong medications and immediate steps taken. "We inserviced the staff on medication administration and accepted professional practice." The DON indicated it was against facility policy for nursing staff to administer medications prepared by another staff member and it was not accepted professional practice to pre-set medications.<br><br>During an interview on 2/3/16 at 3:05 p.m., the ADON (Assistant Director of Nursing) indicated it was not acceptable professional practice to pre-set medications or give medications prepared by another nurse. "That's nursing 101. We were taught not to do that. After this incident, we included it as part of the nursing orientation."<br><br>Review of a current policy, dated | | | |

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| | 4/20/2012, titled "Medication Preparing Oral Tablets or Capsules", was reviewed on 2/3/16 at 1:30 p.m. The policy indicated the following:<br>"Purpose: To provide guidelines for preparing oral tablets or capsules for administration...<br>16. Stay with the resident until the medication has been swallowed. Do not leave the medication for the resident to take later or give to any other staff member to give to the resident...."<br><br>This federal tag relates to Complaint IN00192403.<br><br>3.1-35(g)(1) | | | |
| F 0333<br>SS=G<br>Bldg. 00 | 483.25(m)(2)<br>RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br>The facility must ensure that residents are free of any significant medication errors.<br>Based on record review and interview, the facility failed to ensure residents were free from significant medication errors resulting in the admittance of a resident to the hospital with a diagnoses of drug overdose in 1 of 4 residents reviewed for medication administration. (Resident C)<br><br>Findings include:<br><br>The clinical record of Resident C was | F 0333 | Resident C's physician was immediately notified and resident was monitored for severe sedation, confusion or abnormal bleeding per MD instruction. There were no other residents affected, as of the results of our investigation found the orientee did not administer medications without direct supervision of her preceptor except for this one incident. RN #5, LPN #6 and orientee were counseled and received one-on-one in-servicing on | 02/04/2016 |

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| | reviewed on 2/2/16 at 2:43 p.m. Diagnoses included, but were not limited to, hypertension, diabetes type 2, dementia, atrial fibrillation, chronic heart failure and acute cholecystitis.<br><br>Review of a nursing note, dated 1/27/16, indicated Resident C had received the following medications intended for another resident (Resident D) at 7:30 p.m.:<br>Carbidopa-Levadopa(antiparkinsons) 25-100 mg, Olanzapine (antipsychotic) 20 mg, gabapentin (anticonvulsant) 300 mg, docusate (laxative) 100 mg, haloperidol (antipsychotic) 10 mg and Diazepam (anticonvulsant) 2 mg. The physician was notified and ordered Resident C be monitored and sent to the hospital for any symptoms and severe sedation, confusion or abnormal bleeding.<br><br>Review of a nursing note, dated 1/28/16 at 2:30 a.m., indicated Resident C was found on the floor in his room. The nursing note also indicated "Resident was alert to self and seemed to be alert to surroundings at time but was unable to make it voiced due to resident slurring words". Resident C was sent to the hospital for evaluation and treatment.<br><br>Review of the hospital Pre-Arrival | | facility Medication Administration Policy. RN #5, LPN #6 and orientee each provided return demonstration on correct procedure of medication administration to a Nurse Manager. A shift-to-shift in-service was immediately placed for nurses/QMA's on facility Medication Administration Policy. Medication Administration Policy was added to facility nursing orientation packet. Nurse Managers will complete medication administration skill checks with new orientees upon hire. DON/Designee completed medication administration skill checks with nurses/QMA's. DON/Designee will complete medication administration skill checks with 3 nurses/QMA's every 4 months, on-going to ensure residents are free of significant medication errors. Results of these audits will be forwarded to QA for review monthly X3 then quarterly. | |

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| | Summary dated 1/28/16 indicated Resident C was to arrive to the emergency department via ambulance due to being lethargic due to wrong medications.<br><br>Review of the ED Physician Progress Note, dated 1/28/16 at 3:51 a.m., indicated the reason for the emergency department visit was accidental overdose. At 5:49 a.m. Resident C's reevaluation indicated "pt [patient] is still very lethargic. Plan will be to admit him. Impression and Plan: Alteration of consciousness, Accidental drug overdose, Bradycardia, Fall". Resident C's blood pressure was 192/79.<br><br>Review of the inpatient hospital Discharge Summary, dated 1/30/16 at 3:05 p.m., indicated Resident C had been discharged with the following diagnoses: altered mental status secondary to accidental drug overdose, hypertension uncontrolled, fall at skilled nursing facility and sinus bradycardia.<br><br>During an interview on 2/3/16 at 3:00 p.m., LPN #6 indicated she had asked another nurse to administer medication to Resident D on the skilled care unit. LPN #6 indicated she had pre-set the medications and gave them to the other nurse to administer to Resident D. "I | | | |

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| | know I'm not supposed to but I pre-set his (Resident D) meds (medications) and gave them to (RN #5) to give."<br><br>During an interview on 2/3/16 at 2:50 p.m., RN #5 indicated she had received pre-set medications for Resident D from LPN #6. "I popped his (Resident C) meds to give it to him. Another resident distracted me and I handed his (Resident C) meds to the orientee. I gave her the wrong meds. I had another resident's medications because I was passing his (Resident D) meds for another nurse. We aren't supposed to pre-set meds and I never do. Guess it was some bad decisions. I know I'm not supposed to give meds pulled by another nurse, but I was just trying to help out." RN #5 indicated she was going to watch the orientee give the medications to Resident C, but the orientee had given the medications by the time she arrived to the resident's room.<br><br>During an interview on 2/3/16 at 3:05 p.m., the DON (Director of Nursing) indicated the medication error had been reported and investigated. The investigation report was provided for review at this time. The report indicated Resident C had been given the wrong medications and immediate steps taken. "We inserviced the staff on medication | | | |

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| | administration and accepted professional practice." The DON indicated it was against facility policy for nursing staff to administer medications prepared by another staff member and it was not accepted professional practice to pre-set medications.<br><br>During an interview on 2/3/16 at 3:05 p.m., the ADON (Assistant Director of Nursing) indicated it was not acceptable professional practice to pre-set medications or give medications prepared by another nurse. "That's nursing 101. We were taught not to do that. After this incident we included it as part of the nursing orientation."<br><br>This federal tag relates to Complaint IN00192403.<br><br>3.1-25(b)(9)<br>3.1-48(c)(2) | | | |