

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155377	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/14/2014
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NAME OF PROVIDER OR SUPPLIER SEYMOUR CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 707 S JACKSON PARK DR SEYMOUR, IN 47274
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F000000	<p>This visit was for the Investigation of Complaints IN00139132 and IN00142209.</p> <p>Complaint IN00139132-Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F333.</p> <p>Complaint IN00142209-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 9,10, 13, & 14, 2013</p> <p>Facility number: 000272 Provider number: 155377 AIM number: 100274710</p> <p>Survey Team: Gwen Pumphrey, RN-TC</p> <p>Census Bed Type: SNF: 13 NF: 76 Residential: 5 Total: 94</p> <p>Census Payor Type:</p>	F000000	<p>PREPARATION AND/OR EXECUTION OF THE PLAN OF CORRECTION IN GENERAL, OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR AGREEMENT BY THIS FACILITY OF THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THIS STATEMENT OF DEFICIENCIES. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. The facility is requesting a DESK REVIEW of compliance for this plan of correction.</p>	
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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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F000282 SS=D	<p>Medicare: 13 Medicaid: 76 Private: 5 Total: 94</p> <p>Sample: 14</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 21, 2014 by Cheryl Fielden RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review the facility failed to ensure physician orders were properly transcribed and completed as ordered. This deficient practice affected 2 of 10 residents reviewed in a sample of 14 (Resident H and M).</p> <p>Findings include:</p>	F000282	<p>What corrective action (s) will be accomplished for those residents found to have been affected by the deficient practice;*Resident H expired 12/19/13*Resident M-facility has ensured that only one provider is currently managing resident Dilantin medication and all corresponding labs.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken;*All</p>	02/10/2014			

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	<p>Resident H's clinical record was reviewed on 1/14/13 at 10:52 a.m. Resident H was admitted on 11/26/13 and expired in the facility on 12/19/13. She had diagnoses including but not limited to, high blood pressure, hypothyroidism, and reflux.</p> <p>A physician's order dated 11/26/13 at 5:00 p.m., stated Morphine 0.5ml(milliliters) every 8 hours scheduled and every 4 hours as needed for pain. The Medication Administration Record [MAR] for November and December 2013 was reviewed. The MAR lacked documentation that Resident H received Morphine 0.5 ml every 8 hours for the following dates:</p> <ul style="list-style-type: none"> -November 27th, 12 am dose -December 1st, 8 am, 4pm, 12 am dose -December 2nd, 8am, 4pm, 12am dose -December 3rd, 8am, 4pm, 12am dose -December 4th, 8am, 4pm, 12am dose -December 5th, 8am, 4pm, 12am dose -December 10th, 12 am dose -December 11th 12am dose -December 17th 12am dose <p>The clinical record lacked</p>		<p>residents have the potential to be affected by this alleged deficient practice.*Directed in-service training for nurses regarding facility policy and on medication errors and appropriate documentation provided by DNS/designee by 2/10/2014 with post-test included.*DNS and nurse managers have conducted an audit of all resident MARs to ensure physician orders have been properly transcribed.*Nurse managers to provide daily audit of MARs to ensure accurate transcription of orders administration of medications with appropriate documentation of refusals.*Pharmacy re-writes to receive second check by nurse managers only to prevent error in transcription.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;*Directed in-service training for nurses regarding facility policy on medication errors and appropriate documentation, and completion of physician orders provided by DNS/designee by 2/10/2014 with post-test included.*Nurse managers to provide daily audit of MARs to ensure accurate transcription of orders and administration of medications with appropriate documentation of refusals.*Pharmacy re-writes to receive second check by nurse</p>	

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	<p>documentation of Resident H's refusal to the medication on these dates.</p> <p>In an interview on 1/14/14 at 2:30 p.m., LPN #1 stated this error was a transcription error. She indicated the managers are responsible for rewrites, and for making sure physician orders are carried over from month to month.</p> <p>On 1/14/14 at 2:34 p.m., LPN #2 indicated, "I think that's our fault, the managers do the rewrites."</p> <p>In an interview on 01/14/14 at 4:30 p.m., the Director of Nursing Services(DNS) stated Resident H's family was notified, the hospice physician was notified. She indicated Resident H had no adverse side effects from missing the doses of medication.</p> <p>Resident M's clinical record was reviewed on 1/14/14 at 10:37a.m. Resident M was admitted on 9/19/13. He had diagnoses including but not limited to seizures, insomnia, and stroke. A physician's order dated 11/29/13 (untimed) stated, discontinue Dilantin 200mg(milligrams) BID, Dilantin 200mg in the morning, Dilantin</p>		<p>managers only to prevent errors in transcription.*To ensure compliance, the DNS/designee will be responsible for ongoing compliance related to medication/transcription errors.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place; and by what date the systemic changes will be completed.*To ensure compliance, the DNS/designee is responsible for the CQI audit tools for medication errors and refusal of medications and treatments. These tools will be utilized weekly x 4 weeks; bi-weekly x 2 months, monthly x 6 months; and then quarterly to encompass all shifts until continued compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved an action plan will be developed to ensure compliance.*Date of compliance: 2/10/2014</p>				

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	<p>250mg in the evening.</p> <p>Resident M's MAR for November 2013 indicated he did not receive any doses of Dilantin on November 30.</p> <p>In an interview on 1/14/14 at 4:30p.m., the DNS indicated, "I have personally adopted Resident M. I think the confusion with his medications was due to the providers. At one point three providers were adjusting his treatment plan. We were trying to make sure his lab levels were therapeutic and his medications were being adjusted frequently. Now we have that under control."</p> <p>A policy on physician orders was requested on 1/11/13 at 2:30 \p.m. The DNS indicated the facility does not have a policy on physician orders and the facility "follows state regulations regarding transcription of physician orders."</p> <p>This Federal tag relates to Complaint IN00139132.</p> <p>3.1-35(g)(2)</p>				

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>Based on record review and interview the facility failed to ensure residents did not encounter significant medication errors. This deficient practice affected 1 of 11 residents reviewed for medications in a sample of 14. (Resident N).</p> <p>Findings include:</p> <p>Resident N was admitted to the facility on 5/2/13. Resident N had diagnoses including but limited to diabetes, obesity, high blood pressure, and pneumonia.</p> <p>Resident N's clinical record was reviewed on 1/14/14 at 10:09 a.m., the electronic record listed an allergy to Zosyn. Resident N's Medication Administration Record [MAR], a paper record, did not list Zosyn as an allergy.</p> <p>A physician order dated, 1/3/14 (untimed) indicated Zosyn 3.375 gm</p>	F000333	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;*Resident N's allergy profile was immediately updated on both electronic medical record and paper MAR.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken.*All residents have the potential to be affected by the alleged deficient practice.*100% audit of resident allergies included in both paper MAR and electronic medical record to be conducted by nurse management staff.*Directed in-service training for nurses regarding facility policy on medications errors and appropriate documentation, refusal of medications/treatments,</p>	02/10/2014

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	<p>(grams) intravenously every 6 hours for 5 days.</p> <p>Resident N's MAR indicated the Zosyn 3.375 gm (grams) was administered 4 times each day on January 4, 5, 6, and 8, 2014. The medication was administered 3 times on January 7, 2014.</p> <p>The nurses notes dated 1/4/14 at 4:59 p.m., 1/5/14 at 12:53 a.m., 1/5/14 at 8:46 p.m., 1/6/14 at 1:39 p.m., and 1/8/14 at 9:21p.m. indicated there were no adverse side effects from Resident N receiving the medication.</p> <p>A physician order dated 1/8/14 (untimed) indicated Zosyn 3.375 gm (grams) intravenously every 6 hours for 5 days.</p> <p>Resident N's MAR indicated the Zosyn 3.375 gm (grams) was administered 4 times on January 9 and 10, 2014. The medication was administered twice on January 11, 2014.</p> <p>The nurses notes dated 1/10/14 at 2:56 a.m., 1/10/14 at 5:40 p.m., and 1/11/14 at 3:09 a.m. indicated Resident N had no adverse side effects from the medication.</p>		<p>nurse responsibilities regarding relay of resident allergies to prescribing physicians, and completion of physician orders provided by DNS/designee by 2/10/2014 with post-test included. *The medical records coordinator is to perform a second-check allergy review/audit of all new admits within the first 72 hours to ensure accuracy between the electronic medical record and paper MAR.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;*100% audit of resident allergies included in both paper and electronic MAR to be conducted by nurse management staff.*Directed in-service training for nurses regarding facility policy on medication errors and appropriate documentation, refusal of medications/treatments, nurse responsibilities regarding relay of resident allergies to prescribing physicians, and completion of physician orders provided by DNS/designee by 2/10/2014 with post-test included.*The medical records coordinator is to perform a second-check allergy review/audit of all new admits within the first 72 hours to ensure accuracy between the electronic medical record and paper MAR.*To ensure compliance the DNS/designee will be responsible</p>	

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	<p>The nurses note dated 1/11/14 at 10:30 a.m., indicated, "Presents with increased pruitis and red, blotchy skin to both trunk and BUE [bilateral upper extremities]..."</p> <p>A physician order dated 1/11/14 (untimed) indicated to discontinue Zosyn.</p> <p>The nurses notes dated 1/13/14 at 5:07p.m. indicated, "...Resident has some c/o[complaints of] itchiness and there is some evident rash on arms. Some c/o [complaints of] pain treated effectively with prn [as needed medication]."</p> <p>The nurses notes dated 1/14/14 at 2:56 p.m. indicated, "Resident continues to c/o [complain of] itching, "all over", redness continues to back and extremities x[times]4, prn [as needed medication] benadryl given earlier in shift with some effect."</p> <p>The medical record lacked documentation of Resident N receiving a medication that she may be allergic to.</p> <p>On 1/14/14 at 4:24p.m., the Director of Nursing Services (DNS) indicated</p>		<p>for on-going compliance related to medication/transcription errors.</p> <p>How the correction action(s) will be monitored to ensure the deficient practice will not recur, ie.,what quality assurance program will be put into place; and by what date the systemic changes will be completed.*To ensure compliance, the DNS/designee is responsible for the CQI audit tools for the medication errors. This tool will be utilized weekly x 4 weeks; bi-weekly x 2 months; monthly x 6 months; and then quarterly to encompass all shifts until continued compliance is maintained for two consecutive quarters. Results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved, an action plan will be developed to ensure compliance.*Date of compliance 2/10/2014.</p>				

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	<p>medical records is responsible for ensuring the electronic and paper clinical records have accurate information related to allergies. She indicated the facility uses an internal audit tool to track medication errors. In addition, the resident is monitored, the physician and family were notified of the error.</p> <p>A confidential interview indicated, " if there was a medication error, the DNS and physician are notified and we have to to hot charting."</p> <p>A second confidential interview indicated, "Resident N's paper MAR and electronic MAR don't match. She got Zosyn and she was allergic. She had a rash and her lips were swollen."</p> <p>A copy of the policy and procedure titled, "Medication Errors" was provided by the DNS on 1/14/14 at 4:30p.m. The policy indicated, " It is the policy of this provider to ensure residents residing in the facility are free of medication errors. Documentation in the medical record will include physicians/family notification, type of error, and assessment of resident."</p> <p>This Federal tag relates to</p>				

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	<p>Complaint IN00139132.</p> <p>3.1-25(b)(9)</p> <p>3.1-48(c)(2)</p>			