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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155217 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 08/13/2014 |
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| NAME OF PROVIDER OR SUPPLIER WATERS OF HUNTINGBURG THE | STREET ADDRESS, CITY, STATE, ZIP CODE 1712 LELAND DR HUNTINGBURG, IN 47542 |
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| F000000 | <p>This visit was for the Investigation of Complaint IN00152649, Complaint IN00153773, and Complaint IN00154252.</p> <p>Complaint IN00152649 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00153773 - Substantiated, Federal/State deficiencies related to the allegations are cited at F333.</p> <p>Complaint IN00154252 - Unsubstantiated, due to lack of evidence.</p> <p>Survey dates: August 11 and 13, 2014</p> <p>Survey Team: Anne Marie Crays, RN</p> <p>Facility number: 000122 Provider number: 155217 AIM number: 100290560</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 14 Medicaid: 37</p> | F000000 | | |

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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| F000333 SS=G | <p>Other: 18 Total: 69</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review,</p> | F000333 | F333 Preparation and/or execution | 08/14/2014 |
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| | <p>the facility failed to ensure a resident received her prescribed medications, but instead received another resident's medications, resulting in confusion, a change in vital signs, and breathing difficulties and resulting in an emergency room visit. This affected 1 of 6 residents reviewed for medications, in a sample of 9. Resident B</p> <p>Findings include:</p> <p>1. The clinical record of Resident B was reviewed on 8/11/14 at 2:00 P.M. Diagnoses included, but were not limited to, congestive heart failure, dementia, coronary artery disease, and COPD.</p> <p>A Minimum Data Set (MDS) assessment, dated 5/12/14, indicated the resident scored 15 out of 15 for cognition, indicating no memory impairment.</p> <p>Progress Notes included the following notations:</p> <p>7/30/14 at 1:15 A.M.: "Resident states she is tired, PEARLA [pupils equal and reactive to light], grasps equal, no complaints voiced, will monitor."</p> <p>7/30/14 at 2:00 A.M.: "B/P-170/100, T-97.4, P-64, R [respirations] 12, O2 [oxygen] sat 95% on RA. Breathing</p> | | <p>of the plan of correction in general, or this corrective action in particular does not constitute and admission by the facility of 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.</p> <p>F333-G RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>It is the intent of this facility to ensure that all residents receive their prescribed medications.</p> <p>1. Actions Taken:</p> <p>A) Resident B was assessed by facility nurses and sent to ER to be seen by physician and placed in an observation bed to ensure that there would be no negative outcomes.</p> <p>B) Nurse that was involved in this med error was terminated.</p> <p>C) DON/Designee reviewed MAR's as well as the residents on the unit to ensure that all residents were given the proper medication.</p> <p>D) One-on-one in-services began immediately.</p> <p>E) Medical Director in facility at time of notification and medication error immediately taken to QA meeting.</p> <p>2. HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED WHO MAY HAVE THE POTENTIAL TO BE AFFECTED:</p> <p>A) DON/Designee reviewed MAR's as well as the residents on the unit</p> | |

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| | <p>labored Cushmal [sic] [deep, labored, gasping breathing] respirations noted, resident has slurred speech skin cool and wet, accucheck 159 mg/d., when offered a cup she could not hold it, she c/o [complained of] dry mouth, resident sl. confused she didn't recognize she had a brief on...Complained she was having trouble breathing, and weakness. Will monitor."</p> <p>7/30/14 at 2:40 A.M.: "[Name of physician] notified and orders received to send to Emergency room for evaluation and treatment, resident still having labored breathing."</p> <p>A transfer report, dated 7/30/14 at 2:37 A.M. [sic], indicated, "Chief complaint (reason for transfer), ER [emergency room] for Eval [evaluate] and treat, change in cognition - slurred speech, sl confused, weakness...[change] in vital signs...Resident suffered a Med. Error and was given another Resident's meds...Medication given: Seroquel 150 mg - 1 [an antipsychotic medication], Cymbalta 60 mg - 1 [an antidepressant medication], Ferrous Sulfate 325 mg - 1 [an iron supplement], Mucinex DM 3-600 ER - 1 [a cough medication], Phenytoin ER cap 100 mg - 2 [a medication used to prevent seizures], Tiagabine HCL 4 mg - 1 [a medication</p> | | <p>to ensure that all residents were given the proper medications. As a result of this review, no other resident was identified as being affected by this deficient practice.</p> <p>3. MEASURES TAKEN:</p> <p>A) DON/Designee in-serviced all nurses relating to the policy & procedure of medication distribution with return demonstration to ensure compliance with policy & procedures.</p> <p>B) The results of these observations will be discussed in morning Managements meeting with IDT to identify and possible issues.</p> <p>4. HOW MONITORED:</p> <p>A) During specific orientation of all new nurses DON/Designee will do the hands on training of medication distribution with return demonstration.</p> <p>B) DON/Designee will observe random med passes on random shifts to ensure that nursing staff are following policy & procedures to ensure compliance and resident safety.</p> <p>C) Consultant Pharmacist will continue to do the on-site monthly reviews which includes med pass and med chart review to ensure staff is following policy & procedures.</p> <p>D) The results of these observations will be discussed in morning Management meeting with IDT to identify any possible issues.</p> <p>E) A summary of the DON/Designee training, random</p> | |

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| | <p>for seizures], Carb/Levo ER 50/200 mg - 1 [a medication used for Parkinson's disease], Norco 10/325 mg - 1 [a pain medication], Carb/Levo 25/100 mg - 2 [a Parkinson's disease medication], Entacapone 200 mg - 1 [a Parkinson's disease medication], ? [sic]Lactulose 10 gm/15 - 60 ml [a laxative] given."</p> <p>The resident was transferred by ambulance to the Emergency room on 7/30/14 at 3:25 A.M.</p> <p>A hospital ER report, dated 7/30/14 at 4:00 A.M., indicated, "Course of Care: after initial presentation it was found out that the patient was also sent for evaluation for medication given in error. poorly [sic] at 8 PM last night the patient was given Seroquel, Cymbalta, ferrous sulfate, is next DM [sic], phenytoin, tiagabine, carbo/levodopa, entacapone and lactulose last night in error. She was given another nursing home residence [sic] medications. She was watched for a time and [physician] was notified. She was sent here because of some increased lethargy and fatigue. Patient was given a duo neb [respiratory treatment] treatment in route and her shortness of breath symptoms remained improved through her ER stay...Presently the patient is stable she is slightly somnolent [abnormally drowsy] but easily</p> | | <p>med pass observations will be added to the monthly QA meeting for determination of ongoing monitoring.</p> <p>5. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of compliance is, August 14, 2014.</p> | |

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| | <p>arouseable to voice. Her shortness of breath symptoms have not worsened...Clinical Impression: Acute dyspnea (resolved), Multiple medication ingestion/error...."</p> <p>A facility nursing Progress Note, dated 7/30/14 at 1:24 P.M., indicated, "Late Entry for 7/29/14: During evening medication pass it came to my attention that I had given the wrong medications to this resident d/t [due to] I had set up medications for another resident with the same initials because she had quite a few meds and I thought I would save time. When, at 8:30 pm I realized my mistake, I called [name of physician] answering service to have him paged. I then went into the resident's room and checked her eyes, PERL, and bilateral hand grips were equal. I talked to the resident and asked her how she was feeling and she said she felt ok. [Physician] returned my call at approx. 9:15 PM and informed me to monitor her for oversedation and perform neuro checks q [every] 1 hour x 6 hours and to call him back if she showed signs of oversedation...called resident's son...he didn't want her to know because she would have an anxiety attack...At 10:00 PM resident's vital signs were: BP 129/77, T 98.1, R 18...."</p> <p>On 8/11/14 at 3:30 P.M., during an</p> | | | |

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| | <p>interview with the Director of Nursing (DON), she indicated LPN # 1 prepared the residents' medications prior to administering them, and gave Resident B the wrong medications. She indicated LPN # 1 gave Resident B the medications she had set up for Resident D.</p> <p>On 8/11/14 at 4:00 P.M., during an interview with the Administrator and DON, the Administrator indicated LPN # 1 was terminated over this medication error.</p> <p>On 8/13/14 at 1:00 P.M., during an interview with the DON, she indicated staff were not to set up their medications prior to administering them, and she had inserviced staff after this incident.</p> <p>2. According to "Nursing 2014 Drug Handbook," the medications that the resident received included the following adverse reactions:</p> <p>Seroquel: dizziness, headache, somnolence, tachycardia [rapid heart rate], dyspnea [shortness of breath]</p> <p>Cymbalta: fatigue, headache, somnolence, hypertension, increased heart rate</p> <p>Ferrous Sulfate: nausea, diarrhea</p> | | | |
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| | <p>Phenytoin: decreased coordination, mental confusion, slurred speech</p> <p>Tiagabine: somnolence, confusion, generalized weakness</p> <p>Carbo/Levodopa: confusion, dizziness, cardiac irregularities, hypertension, dyspnea</p> <p>Entacapone: somnolence, fatigue, dyspnea</p> <p>Lactulose: abdominal cramps, diarrhea, nausea</p> <p>3. On 8/13/14 at 1:00 P.M., the DON provided the current facility policy, "Drug Administration - General Guidelines," dated June 19, 2012. The policy included: "Medications are administered at the time they are prepared. Medications are not pre-poured unless the nurse is using a med card specifying the resident's name, the medication, dose and frequency...Six 'Rights' for Administration of Medications, 1. The right resident...2. The right drug...3. The right dose...4. The right dosage form...5. The right time...6. The right route...."</p> <p>This Federal tag relates to Complaint</p> | | | |

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| | IN00153773. 3.1-25(b)(5) 3.1-25(b)(9) | | | |