STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155740	A. BUILDING 00 B. WING	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TIMBERCREST CHURCH OF THE BRETHREN HOME	2201 EAST ST NORTH MANCHESTER, IN 46962

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00381925. Complaint IN00381925 - Substantiated. Federal/state deficiency related to the allegation is cited at F760. Survey date: June 9, 2022 Facility number: 000448 Provider number: 155740 AIM number: 100275140 Census Bed Type: SNF/NF: 52 Residential: 80 Total: 132 Census Payor Type: Medicare: 1 Medicaid: 24 Other: 27 Total: 52 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on June 15, 2022.	F 0000		
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to follow physician order's for medication administration and monitoring for 3 of 3 residents	F 0760	Preparation and/or execution of this plan do not constitute admission or agreement by	06/27/2022

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 determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	reviewed for physician orders (Resident B, C and D). Findings include: An Indiana Department of Health (IDOH) reportable was provided by the Director of Nursing (DON) 6/9/22 at 10:23 a.m. The reportable indicated the alleged event occurred on 5/31/22 when Resident B received the wrong dose of Lyrica (to treat neuropathic pain) on 5/25/22. The resident had an order for Lyrica 50 mg at 9:00 a.m. and 150 mg at 9:00 p.m. On 5/25/22, the morning dose of 150 mg was given instead of 50 mg. The resident demonstrated increased lethargy and her oxygen saturation dropped between 70% and 80% on room air. Oxygen was applied and deep breathing was encouraged. The oxygen saturation returned to 97% and oxygen was discontinued on 5/25/22. The follow-up included to provide increased alerts differentiating the Lyrica 50 mg from the Lyrica 150 mg on the medication cards. A Medication Error Report indicated the errors occurred on May 24, 25 and 30, 2022. The physician was notified on 5/31/22 at 8:00 p.m. after LPN 1 noted the error. Review of the controlled drug record, the evening dose of 150 mg was signed off on 5/24/22 at 8:15 a.m., and 5/25/22 at 8:15 a.m. Review of the controlled drug record for Lyrica 50 mg morning dose, the wrong medication was given on 5/27/22 at 9:24 p.m., and 5/30/22 at 8:00 p.m. 1. The clinical record for Resident B was reviewed		Timbercrest that a deficiency exists. This plan is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. 1. Immediate action taken for the resident(s) found to have been affected include: Resident B was previously identified and treated. No long term adverse effects were identified. Resident C and D's previously identified BP that was within the hold limitations did not lead to any adverse effects. BP on 6-9-22 during survey was within normal limits. 2. Identification of other residents having the potential to be affected was accomplished by: All residents receiving medications have the potential to be affected by this practice. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Audit was completed on residents with medications that include hold parameters and medication orders involving different dose of same medication from 6-1-22 to 6-21-22. Education was given and documented to 2 identified QMAs	

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	on 6/9/22 at 8:41 a.m. Diagnoses included, but were not limited to, fatigue, iron deficiency anemia, repeated falls and osteopenia. The most recent Admission Minimum Data Set (MDS) assessment, dated 5/21/22, indicated the resident was cognitively intact. A health care plan, dated 5/5/22, indicated the resident was at risk for generalized pain due to chronic pain. Interventions included, but were not limited to, pain medication if distraction does not work. Another health care plan, dated 6/9/22, indicated the resident received active range of motion six days per week related to chronic pain. Interventions included, but were not limited to, observe for pain or discomfort and medicate per physician orders. A physician's order, dated 4/30/22, indicated to give Lyrica 150 mg at bedtime and 50 mg in the morning. A progress note, dated 5/22/22 at 9:30 p.m., indicated the residents blood pressure was consistently low; 87/46, 86/55 and 86/54. The physician was notified and a order was received to hold amlodipine (treat high blood pressure) for 3 days then to report back on blood pressures. A progress note, dated 5/25/22 at 10:07 a.m., indicated a wound nurse called and reported the resident's oxygen saturation had dropped down to 74%. They were able to get the level up after removing her mask and having her take deep breaths. Oxygen was applied at 1 liter and her oxygen saturation came up to 97%.		who potentially caused a medication error related to hold parameters on 6-10-22. Medication administration policies were reviewed and found sufficient. All nurses and QMAs are currently reviewing the "Medication Administration – General Guidelines" and "Administration Procedures for All Medications policies. Completion of this review is scheduled by 6-26-22. Nurses and QMAs are also completing the "Avoiding Common Medication Errors" in-service, due by 6-26-22. New process are being trialed in Healthcare to better identify medication cards with different dosages. This includes the coloring the top corner of a card red with red ink for AM medications and black ink coloring the top corner of the medication card correlating to the PM medications. This color identification will be completed by the QMA or nurse who initiates the new medication card. Highlight any special instructions related to different dose medications. Date and initial each medication card when initiated. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** Random medication administration audits will be conducted by the	

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	On 5/25/22 at 1:18 p.m., the physician was notified of a change in condition due to resident requiring oxygen. A progress note, dated 5/25/22 at 2:12 p.m., indicated the resident returned from wound clinic appointment and her oxygen level was 71% on room air. 1 liter of oxygen was applied and her saturation came up to 95%. The resident was alert, oriented and her speech clear, but stated she was very sleepy from her appointment. A progress note, dated 5/25/22 at 9:43 p.m., indicated the resident continued to need oxygen at 2 liters. She required frequent reminders to keep in place and when removed, dropped to 85%. The resident appeared to be sleeping more throughout the evening. A progress note, dated 5/26/22 at 6:46 p.m., indicated the resident was feeling a little weaker and her oxygen saturation without oxygen was 94%. A progress note, dated 5/31/22 at 8:12 p.m., indicated the resident received the wrong dose of Lyrica on 05/24/22, 05/25/22, and 05/30/22. The physician and family were notified of the medication error. During an observation with the DON on 6/9/22 at 10:58 a.m., the medication cards had A.M. and P.M. noted on each card with a corresponding controlled drug record. The times were highlighted to reflect the time the medication was to be given. During an interview on 6/9/22 at 11:02 a.m., QMA 2 indicated she gave 150 mg in the morning instead of 50 mg. The resident was lethargic and		DON or designee, with a nurse or QMA once a week on different shifts for one month. Chart review of medications with hold parameters and different dose of same medication orders will be completed after the first month. Medication administration audits will then be once a month for two months. This information will be reviewed at the October QA Committee to determine need for continuation of audit. If medication error rate is 5% or greater, continued auditing will occur. Audit results will be reviewed by the Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. Corrective action completion date: 6-27-22	

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	her oxygen saturation had dropped. She received education on medication administration and the 5 rights. 2. The clinical record for Resident C was reviewed on 6/9/22 at 12:51 p.m. Diagnoses included, but were not limited to, anxiety disorder, chronic kidney disease, Alzheimer's disease and hypertension. The most recent quarterly MDS assessment, dated 4/20/22, indicated the resident was severely cognitively impaired. A health care plan, dated 3/7/19, indicated the resident had complications related to diabetes and hypertension. Interventions included, but were not limited to, administer medication as ordered and monitor blood pressure. A physician's order, dated 8/13/21, indicated to give metoprolol (to treat high blood pressure) 25 mg daily. The order indicated to hold the medication if her pulse was less than 50 beats per minute or systolic blood pressure less than 100. Review of the May MAR, Resident C's blood pressure included the following: a. 5/19/22 - 91/66 b. 5/31/22 - 91/51 c. 6/6/22 - 97/43 d. 6/8/22 - 96/48 Staff failed to withhold the medication ordered by the physician. 3. The clinical record for Resident D was reviewed on 6/9/22 at 12:13 p.m. Diagnoses included, but were not limited to, hypertension, depressive disorder, anxiety and obsessive compulsive disorder.			

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	The most recent quarterly MDS assessment, dated 3/30/22, indicated the resident was severely cognitively impaired. A health care plan, dated 3/15/19, indicated the resident had active hypertension. Interventions included, but were not limited to, administer medication as ordered and notify the physician if the blood pressure exceeds limits established by the physician. A physician order, dated 5/19/22, indicated to give clonidine (to treat high blood pressure) 0.3 mg twice daily. The order indicated to hold the medication if the blood pressure was less than 130/60, recheck in 1 hour. Review of the May MAR, Resident D's blood pressure included the following: a. 5/19/22 - 114/50 b. 5/23/22 - 105/53 and 100/50. Staff failed to withhold the medication ordered by the physician. During an interview on 6/9/22 at 10:53 a.m., the DON indicated she originally reported 1 overdose, but there were actually 2. She did not report the underdose errors since the resident did not have any adverse effects. Three of the 4 staff involved worked for an outside agency, but she did provide education to QMA 2 related to the five rights. During an observation with the DON on 6/9/22 at 10:58 a.m., the medication cards had A.M. and P.M. noted on each card with a corresponding controlled drug record. The times were highlighted to reflect the time the medication was to be given.			

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	During an interview on 6/9/22 at 11:02 a.m., QMA 2 indicated she gave 150 mg in the morning instead of 50 mg. The resident was lethargic and her oxygen saturation had dropped. She received education on medication administration and the 5 rights. During the exit conference, the DON indicated LPN 1 noticed the discrepancies and she was notified on 5/31/22, but the errors occurred starting on 5/24/22. Review of a current policy effective January 2007, titled "MEDICATION ORDERS" provided by the Infection Control Preventionist on 6/9/22 at 3:00 p.m., indicated the following: "Policy Medications are administered only upon the clear, complete, and signed order...." This Federal Tag relates to complaint IN00381925 3.1-25(b)			