

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/15/2015
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NAME OF PROVIDER OR SUPPLIER  WATERS OF INDIANAPOLIS, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 3895 S KEYSTONE AVE INDIANAPOLIS, IN 46227
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00186473.</p> <p>Complaint IN00186473 - Substantiated. Federal/State deficiencies related to the allegations are cited at F333.</p> <p>Survey dates: December 14, &amp;15, 2015</p> <p>Facility number : 000537 Provider number: 155409 AIM number: 100267270</p> <p>Census bed type: SNF/NF: 52 Total: 52</p> <p>Census Payor type: Medicare: 5 Medicaid : 42 Other : 5 Total:52</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Q.R. completed by 14466 on December</p>	F 0000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of 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. <b>The facility respectfully requests paper compliance for this citation.</b></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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F 0333 SS=G Bldg. 00	<p>21, 2015.</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, the facility failed to ensure a resident was free from a significant medication error in that Resident #A had not been correctly identified by the nurse and was given another resident's evening medication in addition to Resident #A's evening medication which resulted in an overdose of medication and overnight hospital stay for 1 of 4 residents reviewed for medication administration. (Resident #A)</p> <p>Findings include:</p> <p>On 12/14/15 at 11:02 a.m., an interview with Resident #A indicated the following:</p> <p>On 10/25/15, at approximately 6:00 p.m., Resident #A was experiencing some pain and used the call light to get assistance from her nurse to request pain medication. No staff responded to the</p>	F 0333	<p>1. The affected resident no longer resides at the facility. Registered Nurse #1 has been reeducated and counseled regarding the deficient practice.</p> <p>2. Residents who receive medications by nursing staff have the potential to be affected by this finding if the required identification of the resident by the administering nurse does not take place prior to the medication administration. All licensed nurses and QMAs currently working at the time of the deficient practice were provided an educational offering on October 30th, 2015 regarding the current medication policy. This policy includes the six rights of medication administration, including right resident, right medication, right dose, right form, right route, and right time. The importance of correct documentation was also noted in the inservice. Registered Nurse #1 was monitored for adherence to the medication policy upon her return to work on November 3rd.</p>	12/16/2015

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	<p>call light so Resident #A went to the nurses station to find her nurse to get the pain medication.</p> <p>Registered Nurse (RN) #1 indicated she would give Resident #A the pain medication and her evening medications. Resident #A took the medication as given and returned to her room.</p> <p>The October 25, 2015 at 6:00 p.m., Medication Administration Record indicated Resident #A received the following scheduled evening medications:</p> <p>Gabapentin 600 mg (milligram), montelukast sodium 10 mg , ropinirole hci 2 mg, simvastatin 40 mg, trazodone hci 50 mg, warfarin 5 mg, Advair inhaler, Caltrate 600-800 mg , Coreg 12.5 mg, colace 8.6- 50 mg, and 2 Norco 10-325 mg.</p> <p>Continued interview with Resident #A indicated at approximately 10:00 p.m., RN #1 entered Resident #A's room with a cup full of pills. At that time, Resident #A indicated to RN #1 that she had already given the evening medications. RN #1 indicated to Resident #A, those were pain pills.</p> <p>Resident #A looked in the medication</p>		<p>2015. Additional monitoring for this licensed nurse occurred on November 8th, 2015, November 23rd, 2015, November 29th, 2015, and December 1st, 2015. No problems were noted in any of the areas of medication administration. Employees on medical leave at the time of the deficient practice were educated upon their return. 3. The DON/Designee will monitor a medication administration three days a week on various shifts to ensure that the nursing staff person who is administering medications follows all requirements prior to administering any medication to any resident. This includes right resident, resident medication, right dose, right form, right route, and right time. This monitoring will continue until four consecutive weeks of zero negative findings are achieved. Medication monitoring will continue on at least one medication pass per week for a period of not less than six months to ensure ongoing compliance and randomly thereafter. Note: Any potential medication error concerns noted during the monitoring will be halted prior to an error taking place. 4. The results of the monitoring will be reviewed at the monthly Quality Assurance meeting. As no errors will be allowed to occur, any potential problems and necessary reeducation or disciplinary action</p>	

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	<p>cup and questioned the pills. "That was too many pills." RN #1 insisted those were the correct pills and sometimes medications can look different, because they come from different manufacturers. Resident #A took the medication. "I did not want the nurse to chart I refused." RN #1 exited the room.</p> <p>After taking the medication and throwing the medication cup in the trash, Resident #A noticed another resident's name on the medication cup and immediately told a staff member the concern.</p> <p>Resident #A was told by staff the medication cup belonged to a resident across the hall. RN #1 returned to Resident #A's room and indicated Resident #A needed to go to sleep. "The medication would not affect your heart medication." Resident #A insisted on going to the hospital.</p> <p>Resident #A's clinical record was reviewed on 12/14/15 at 12:00 p.m. Diagnoses included, but were not limited to: diabetes, asthma, restless leg syndrome, depression, pain, and hypertension.</p> <p>The admissions Minimum Data Set (MDS) assessment indicated Resident #A was interviewable and cognitively intact.</p>		<p>will be discussed. An Action Plan will be written and monitored weekly by the Administrator until resolved. 5. December 16, 2015 The facility respectfully requests an IDR related to the severity of this finding.</p>	

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	<p>Physician's order dated 10/25/15, indicated, Resident #A received the following scheduled medications: Gabapentin 600 mg (milligram) used to treat seizures and diabetic neuropathy, montelukast sodium 10 mg used to treat asthma, ropinirole hci 2 mg (antiparkinson), simvastatin 40 mg (cholesterol), trazodone hci 50 mg (antidepressant), warfari 5 mg (blood thinner), Advair inhaler(antiasthmatic), Caltrate 600-800 mg (calcium with vitamin D), Coreg 12.5 mg (antihypertension), colace 8.6- 50 mg (stool softener), and 2 Norco 10-325 mg (scheduled 3 narcotic used to control moderate to severe pain).</p> <p>Resident #A's current physician's order did not include the following medications, which were given to Resident #A on 10/25/15 at approximately 10:00 p.m.: Morphine ER (extended release)15 mg [milligram] a scheduled 2 narcotic used to control moderate to severe pain, Morphine ER 60 mg a scheduled 2 narcotic used to control moderate to severe pain, Xanax 0.5 mg a schedule 4 narcotic used to treat anxiety/panic attack, Lyrica 50 mg a schedule 4 controlled substance used to treat seizures and neuropathy, Norco 10 xs [times] 2, and atorvastatin</p>			

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	<p>(cholesterol).</p> <p>Nursing progress note dated 10/25/15 indicated, "Resident sent to [local hospital] er [emergency room] for observation."</p> <p>Ambulance dispatch worksheet dated 10/25/15, indicated, chief complaint, "MEDICATION admin [administration] ERROR." nature of dispatch "Overdose." Resident #A's blood pressure at 22:14 (10:14 p.m.) was 188/139. A normal blood pressure was 120/80.</p> <p>Emergency room nursing notes dated 10/25/15, indicated, " Registered Nurse [RN] from [Name of Nursing home] called report, Pt [patient] was given Morphine ER 15 mg [milligram] Morphine ER 60 mg, Xanax 0.5 mg, Lyrica 50 mg, Norco 10 xs [times] 2, and atorvastatin by mistake at 2200 [10:00 p.m.]."</p> <p>Physician Assistant notes dated 10/25/15 indicated, "... History, Ingestion, ... [Resident #A] usually takes 2 Norco 10mg tablets, which she did take this evening. However, she was also given Morphine IR [sic] 15 mg, Morphine ER 60 mg, Xanax 0.5 mg, and Lyrica 50 mg about 1 hour ago. She says she feels sleepy. Pain is currently controlled. ..."</p>			

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	<p>Acute care hospital notes indicated Resident #A was kept overnight for observation due to the ingestion of medication.</p> <p>On 12/15/15 at 11:51 a.m., interview with Registered Nurse #1 indicated, on 10/25/15, around 9:30 p.m., second medication pass was being administered. RN #1 had written Resident #D's name on a medication cup, popped out the pills and proceeded down the hall to give Resident #D the medication. Upon walking down the hall RN #1 indicated there was a distraction and instead of entering Resident #D's room, RN #1 turned the wrong way and entered Resident #A's room. RN #1 indicated Resident #A had a question about one of the pills, but took the medication. RN #1 indicated after exiting the room and returning to the medication cart realized. "I had given the wrong medication. I just didn't check the name on the cup."</p> <p>On 12/14/15 at 2:50 p.m., interview with the Director of Nursing (DON) indicated the only nursing note concerning the medication error was Resident #A was sent to hospital for observation.</p> <p>On 12/15/15 at 11:40 a.m., interview with the Director of Nursing indicated, RN #1 had been suspended after the</p>			

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	<p>medication error. "She [RN #1] had incorrectly identified the resident [Resident #A]."</p> <p>On 12/15/15 at 11:05 a.m., the Director of Nursing (DON) provided facility policy "5.1 DRUG ADMINISTRATION-GENERAL GUIDELINES" dated June 19, 2012, and indicated the policy was the one currently used by the facility. The policy indicated, "...2. Medications are administered in accordance with written orders of the attending physician. ...7. Residents are identified before medication is administered: check identification band, check photograph attached to medical record, ... call resident by name, ...SIX RIGHTS' FOR ADMINISTRATION OF MEDICATIONS 1. The right resident: ...2. The right drug: ..."</p> <p>The Wolters Kluwer Nursing 2014 Drug Handbook, 34th edition, copyright 2015, indicated, "... morphine hcl ... for moderate to severe pain ...Cautions ... Use with caution in elderly ...patients ...Xanax 0.5 mg a schedule 4 narcotic used to treat anxiety/panic attack, Lyrica 50 mg a schedule 4 controlled substance used to treat seizures and neuropathy."</p> <p>This Federal tag relates to Complaint IN00186473.</p>			

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

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FORM APPROVED

OMB NO. 0938-0391

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	3.1-48(c)(2)				