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 10/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY CHARM	3177 MERIDIAN PARKE DR GREENWOOD, IN 46142

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R000000	This visit was for the Investigation of Complaints IN00157460 and IN00157552. Complaint IN00157460 - Unsubstantiated due to lack of evidence. Complaint IN00157552 - Substantiated. State Residential deficiencies related to the allegations are cited at R-241 and R-247. Survey dates: October 14 & 15, 2014 Facility number: 011478 Provider number: 011478 AIM number: N/A Survey team: Diana Zgonc, RN-TC Census bed type: Residential: 95 Total: 95 Census payor type: Medicaid: 54 Total: 54 Sample: 4 These State Residential findings are cited	R000000	"This plan of correction is submitted as required by Indiana Law and does not constitute an admission on the part of Country Charm of the accuracy of the surveyors' findings or any conclusion drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity are correctly applied. Any changes to Country Charm's policies and procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure. Country Charm reserves its right to object to the admission of this Statement of Deficiency or the Plan of Correction in any legal or administrative proceeding. Country Charm submits this plan of correction with the intention that it be inadmissible in any legal aciton against Country Charm or any employee, agent, officer, director, or attorney, or shareholder of Country Charm or affiliated companies."	

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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	in accordance with 410 IAC 16.2-5. Quality review completed on October 16, 2014; by Kimberly Perigo, RN.			
R000241	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure a resident received the correct physician ordered medications which resulted in a medication error and emergency hospital treatment for 1 of 3 residents reviewed for medication administered as indicated by physician's orders in a sample of 3. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 10/14/14 at 2:35 p.m. Diagnoses for Resident #B included, but were not limited to pulmonary osteoenia, hypertension, dementia, osteoarthritis, reflux disease and hypercholesterol.	R000241	1. This self-reported medication error was addressed immediately at the time of the error. The Resident has returned to the Community. The nurse who self-reported the error was counseled and later suspended pending further review. It appears that she took all appropriate professional actions necessary to mitigate the consequences of her error. 2. The Director of Nursing has reviewed all residents' medication administration records against the drug inventory in the Community to ensure no other medication errors have occurred to date. The Director of Nursing has reviewed all nurses' notes for the past month to ensure that no resident presented with	11/10/2014

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	A nurses note dated 9/28/14 at 8:56 p.m., indicated the resident was hard to arouse and lethargic. Blood pressure was 93/33 (below normal) and heart rate was 59 (below normal). An ambulance was called and Resident #B was transported to the hospital emergency room. A hospital note dated 9/28/14 at 9:43 p.m., indicated Resident #B was brought to the ED (emergency department) unresponsive with complaints of drug overdose. The emergency medical staff indicated the resident had been given another resident's medication by accident. The incorrect medications included, Lopressor (hypertensive medication used to lower blood pressure) 50 milligrams (mg), Seroquel (antipsychotic medication) 50 mg, zantac (anti-ulcer medication) 300 mg, Exelon (anti-Alzheimer's medication) 3 mg zoloft (anti-depressant medication) 100 mg, Norco (medication for moderate to severe pain) 5/325 mg and klonopin (anti-convulsant medication) 2 mg. Assessment of the resident indicated the pupils were constricted and only responded to pain. A hospital discharge note dated 10/1/14 at 10:56 a.m., indicated the resident suffered from acute encephalopathy		complaints that could have been the result of a medication error. 3. The Director of Nursing conducted or directed in-service training for all employees assigned to pass medication. All staff were trained on how to recognize signs of possible medication errors. The assigned in-service were completed on or before October 24, 2014. 4. Medication Administration training shall be enhanced in the new employee orientation program and on-going training will occur every six months for all employees who pass medications. Random audits will be performed and documented by the DON and supervisors on each employee administering medications monthly for 6 months to assure that all med passes are done in compliance with the State Laws. Medication Assistance competency Review check off sheets will be used to preform audits and reviewed by the Executive Director and DON. At the completion of the 6 months audits the Executive Director and DON will review all reports and make a final report of any issues found during the 6 month period. The DON and executive director will then determine whether further monitoring is needed according to their final review. 5. This corrective action was completed on or before November10, 2014.	

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	(brain dysfunction) due to unintentional medication overdose likely secondary to a combination of klonopin, zoloft and Norco. Resident #B was given Narcan (counteract opioid/Narco overdose) and atropine (used to treat a slow heart rate or cardiac arrest) by emergency personnel en route to the hospital. During an interview with the Director of Nursing on 10/15/14 at 10:30 a.m., she indicated they were unsure how the nurse gave the wrong medications to the resident. A current undated facility policy titled, "Oral Medication Administration", provided by the DON on 10/14/14 at 10:30 a.m., indicated, "Policy: Oral medications are administered to the resident as prescribed by a physician ... Procedure: 1. ... Check medication sheet against the instructions on the medication bottle insuring all 6 rights of medication administration right drug, right route, right time, right doze (sic), right person and right documentation. 2. Identify the resident and insure the six rights... 4. ...Repeat the 6 rights of administration of medication."			

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R000247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure a medication error was documented in the resident's medical record according to facility policy for 1 of 3 resident's reviewed for documentation in a sample of 3. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 10/14/14 at 2:35 p.m. Diagnoses for Resident #B included, but were not limited to pulmonary osteoenia, hypertension, dementia, osteoarthritis, reflux disease and hypercholesterol. A hospital note dated 9/28/14 at 9:43 p.m., indicated Resident #B was brought to the ED (emergency department) unresponsive with complaints of drug overdose. The emergency medical staff	R000247	1. The self-reported medication error was entered into the resident's nurses' notes as a late entry by the appropriate nurse at the suggestion of the surveyors. The MAR was also noted with a late entry. 2. The Director of Nursing has reviewed all resident records for the past month to ensure that documentation is complete. Her review included comparisons of nurses' notes with medication records and physician orders. 3. The Corporate Quality Assurance Nurse conducted proper documentation training on or before 10/24/14 for all employees who have responsibility for recording resident status. 4. To assure that documentation is in compliance with State Regulations, all necessary charts will be reviewed by the DON and Supervisors to assure that all documentation was properly completed. Any issues will be	11/10/2014

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	indicated the resident had been given another resident's medication by accident. The incorrect medications included, Lopressor 50 milligrams (mg), Seroquel 50 mg, zantac 300 mg, Exelon 3 mg zoloft 100 mg, Norco 5/325 mg and klonopin 2 mg. Assessment of the resident indicated the pupils were constricted and only responded to pain. The record lacked documentation Resident #B was administered incorrect medications or what medications were given. During an interview with the Director of Nursing (DON) on 10/15/14 at 10:30 p.m., she indicated the nurses notes lacked documentation of a medication error or what type of medications were administered to the resident. She also indicated at that time she would have the nurse make a late entry to add the missing information. A current undated facility policy titled, "Medication Errors", provided by the DON on 10/15/14 at 10:30 a.m., indicated, ... 4. On the back of the Medication Sheet write the date, time, actual medication and dosage that was given, "med-error", any action taken (Wellness Director notified, physician notified, etc.)		addressed with the staff member and necessary individual training will be completed to assure that the errors are corrected. 5. Completion of this corrective aciton shall be no later than November 10, 2014	

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	and any additional comments. Sign your initials 5. If a medication is given to the wrong Resident ... Record the details of the medication error on the back of the Medication Sheet and follow the procedures outlined in step 4 (above).			