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
	155167		04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE NORTH	11050 PRESBYTERIAN DR INDIANAPOLIS, IN 46236

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00197728. Complaint IN00197728 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F282, F333, F514 and F9999. Unrelated deficiency is cited. Survey dates: April 18 and 19, 2016 Facility number: 000084 Provider number: 155167 AIM number: 100284600 Census bed type: SNF/NF: 118 Residential: 76 Total: 194 Census payor type: Medicare: 18 Medicaid: 60 Other: 40 Total: 118 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC	F 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Westminster Village North that the allegations contained in the survey report are accurate or reflect accurately the provision of nursing care and service to the Residents at Westminster Village North	

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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	16.2-3.1. Quality review completed by 30576 on April 27, 2016			
F 0282 SS=G Bldg. 00	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. Based on interview and record review, the facility failed to ensure a resident did not receive another resident's medication, resulting in the resident becoming somnolent and unresponsive and requiring emergent care with the use of a medication to reverse the effects of the unresponsiveness for 1 of 3 residents reviewed for the receipt of incorrect medications in a sample of 3. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 4-18-16 at 10:20 a.m. It indicated his diagnoses included, but were not limited to atrial fibrillation, atherosclerotic heart disease, high blood pressure, diabetes and vascular dementia. In an interview with LPN #2 on 4-19-16	F 0282	The facility believes thatit met the requirement that "***The services provided or arranged by thefacility must be provided by qualified persons in accordance with eachresident's written plan of care".*** 1.R.N. # 3 is arecent graduate of an approved school of Nursing. The Nursing curriculum includes practicumscovering the administration of medications. Pharmacology is also a topic of study provided in Nursing School. R.N. # 3 also had a valid license topractice nursing in the State of Indiana, which was awarded to her only afterexhibiting a satisfactory performance on the State required examination for theissuance of a license to practice as a Registered Nurse. Thus, R.N. #3 was, in fact, ***"qualified"***to execute the customary duties performed by a Registered Nurse in the State	05/13/2016

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	at 11:23 a.m., she indicated on the evening of 3-26-16, she was orienting a new nurse, RN #3. She indicated she was observing RN #3 with the entire bedtime medication pass. "Instructed [her] to get [Resident #C]'s blood sugar and get his meds ready while I went to check on two other residents. When I stepped back in the hall, she [RN #3] was gone and I heard her in [name of Resident #B]'s room. [When I got to his room], she was bent over and ready to give him insulin, Lantus, and I stopped her. [Name of Resident #B] does not receive insulin. Saw an empty med cup. She gave [name of Resident #C]'s oral meds to [name of Resident #B]." She indicated the physician and family were also notified of the incident, and passed along information to the next shift as to the incident and the physician's order to continue to monitor the resident closely. "I just wish she would have waited for me like I told her and to ask if she wasn't sure which resident was which, if she wasn't sure." Review of a "Medication Incident Report," dated 3-26-16 and signed by LPN #2, indicated on 3-26-16 at 9:30 p.m., Resident #B received "Norco [used for narcotic pain reliever], Gabapentin [used for neuopathic pain], Depakote [used for mood stabilization], Sinoment		ofIndiana—including the administration of medications. To ensure that thefacility only hires ***"qualified"*** nurses, the following pre-employment screenings areconducted: license verification;criminal background check; reference checks. This has been a long standing practice of the facility. All of the aforementioned pre-employmentscreenings were conducted for R.N. # 3. R.N. # 3 was in orientation at the time ofthis incident. Although she wasobviously ***qualified to administer medications,*** she erred in judgementwhen she chose to proceed with the medication pass without the supervision orconsent of her preceptor. Neither thepreceptor nor any other member of the facility staff could have predicted thatR.N. # 3 would have independently decided to proceed with the medication passwithout the supervision of the preceptor. Said error in the judgment of R.N. # 3 resulted in the medication errorin question. The preceptor had advisedRN #3 not to proceed with the med pass until she returned. R.N. #3 was suspended at the time ofoccurrence, pending an investigation of this incident. R.N. #3 opted to resign her position. 2. No other Residents were impacted by this incident, as the preceptor had remainedwith R.N.#3, except during the brief	

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	[sic] [used for Parkinson's disease], Lipitor [used for hyperlipidemia], Flomax [used for benign prostate hypertrophy]" related to "Nurse administered medication to the wrong resident." Resident #C's recapitulation orders for April, 2016 indicated his oral medications due for 9:00 p.m., or bedtime were the following medications: -Depakote 125 mg (milligrams) and Depakote 250 mg, 3 tabs, to equal a total of 875 mg. -Gabapentin 600 mg. -Sinemet CR (continuous release formula) 50/200 mg. -Lipitor 40 mg. -Flomax 0.4 mg. -Norco 5/325 mg every four hours by mouth as needed for pain. In review of Resident #B's recapitulation orders for April, 2016, he was not ordered to receive any of the medications he received in error. On 4-18-16 at 2:05 p.m., the Administrator provided a copy of a policy entitled, "Medication and Treatment Incidents." This policy had a revision date of 9-15-15 and was indicated to be the current policy utilized by the facility. This policy indicated, "Purpose: To		time that the incident occurred. 3. As a result of this incident and as a meansto ensure ongoing compliance, thecontent of the Orientation Manual for Nurses has been augmented to include anacknowledgement which will require the signature of the orientee. Said acknowledgement will mandate that duringthe orientation process, medications may not be given without the directsupervision of the preceptor. Thefacility's Quality Assurance Nurse conducts the initial orientation for allnewly hired licensed nurses, prior to allowing these individuals to beginorientation on the nursing units. TheQuality Assurance Nurse will be responsible for the presentation of this form and procuring a signature on the same. Pharmacy and Nursing Management staff will conduct random med pass observations weekly x six months. Any identified errors will be given to the Quality Assurance Nurse. 4. Asa Quality Assurance measure, the Quality Assurance Nurse will review this topicduring the facility's monthly Quality Assurance Meetings for the next sixmonths. At the end of the six monthperiod, the Quality Assurance Committee may elect to end the monthly review ofthis topic if 100% compliance is achieved. At the end of the six month period,the Quality	

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	safeguard the Resident from recurrent medication and treatment incidents. Policy: Medication/Treatment incidents are to be reported to the physician and responsible party/family member. A Medication/Treatment incident report are to be completed by the individual noting the error. Medication errors will be reported to ISDH if treatment beyond ER visit required...The Resident is to be observed for adverse reaction to the error. Documentation must be thorough and change in condition reported to the physician. Necessary in-service/re-education of involved individuals and/or all licensed/qualified nursing staff shall be conducted based upon the cause, nature and extent of the error..." This Federal tag relates to Complaint IN00197728. 3.1-35(g)(2)		Assurance Committee may elect to end the monthly review of thistopic if 100% compliance is achieved.	
F 0323 SS=D Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on interview and record review, the facility failed to ensure a resident being transferred from his bed to his wheelchair by a staff member was not left unattended, which contributed to his fall from the bed to floor, resulting in him striking his head and being sent to the emergency room for further evaluation for 1 of 3 residents reviewed for residents sent out of the facility for healthcare services. (Resident #C) Findings include: Resident #C's clinical record was reviewed on 4-18-16 at 11:00 a.m. His diagnoses included, but were not limited to Parkinson's disease, depression, anxiety, dementia and diabetes. In review of Resident #C's clinical record, the nursing progress notes indicated he had an unwitnessed fall on 3-9-16 at 12:30 p.m. It indicated he "was found on the floor face down against table next to his bed [sic] he stated he was reaching for phone, aide [CNA] was getting resident dressed and had transferred resident's [personal safety] alarm to wheelchair and left resident alone so she could go find a hoyer [type of mechanical lifting device] pad. Resident was alert, left side of face was red from hitting the table, ROM [range of	F 0323	1. C.N.A. received additional education on3-10-16 regarding the inappropriateness of leaving a Resident unattendedwithout the alarm in place. 2.C.N.A. assignment sheets and CarePlans will be reviewed for all Residents utilizing an alarm. This will be done to ensure that it isnoted therein that Residents should not be left unattended, when the alarm isnot in place. 3.Additional education will be providedto Certified Nursing Assistants regarding the need to remain with the Residentwhen the alarm is not in use. Random weekly hoyer lift transfers will be completed by Quality Assurance Nurse for six months to ensure facility policy being followed 4.The Quality Assurance team will review any identified hoyer lift transfer errors at monthly QA meetings for six months to ensure staff followingFacility protocol. At the end of the six month period, the QA Committee may elect to end the monthly review of this topic if 100% compliance is achieved	05/13/2016

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	motion] intact, no open areas noted and pupils were not responsive. NP [Nurse Practitioner] gave order to send resident to ER [emergency room], Brother was notified." Review of the emergency room visit from 3-9-16 indicated he was returned to the facility on the same date with instructions for care of contusions of the knees. In an interview with the Director of Nursing on 4-19-16 at 1:20 p.m., provided a copy of a form used for education with the CNA. It indicated on 3-10-16, the CNA was educated regarding, "Residents With Alarms. Those residents with alarms are not to be left alone on the toilet or the side of the bed. Staff is to stay with the resident and make sure that the are safely transferred back to the wheelchair or with the alarms attached...All staff: Alarm sounds: GO TO!!" In review of a care plan for Resident #C, with a creation date of 8-29-15 and revision dates of 11-9-15, 11-27-15 and 3-10-16, it indicated to encourage the resident to transfer with assistance, encourage the resident to use the call light for assistance, to ensure the bedside table is within reach, use of motion detector in his room, personal alarm to			

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	bed and wheelchair and to check the alarm's function each shift and to change the alarm batteries monthly. 3.1-45(a)(2)			
F 0333 SS=G Bldg. 00	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 receive the correct medications, resulting in the resident becoming somnolent and unresponsive and requiring emergent care with the use of a medication to reverse the effects of the unresponsiveness for 1 of 3 residents reviewed for the receipt of incorrect medications in a sample of 3. (Resident #B) Findings include: Resident #B's clinical record was reviewed on 4-18-16 at 10:20 a.m. It indicated his diagnoses included, but were not limited to atrial fibrillation, atherosclerotic heart disease, high blood pressure, diabetes and vascular dementia. Review of Resident #B's nursing progress notes indicated an entry on 3-18-16 at	F 0333	The facility believes thatit met the requirement that "***The services provided or arranged by thefacility must be provided by qualified persons in accordance with eachresident's written plan of care".*** _ 1.R.N. # 3 is arecent graduate of an approved school of Nursing. The Nursing curriculum includes practicumscovering the administration of medications. Pharmacology is also a topic of study provided in Nursing School. R.N. # 3 also had a valid license topractice nursing in the State of Indiana, which was awarded to her only afterexhibiting a satisfactory performance on the State required examination for theissuance of a license to practice as a Registered Nurse. Thus, R.N. #3 was, in fact, ***"qualified"***to execute the customary duties performed by a Registered Nurse in the State	05/13/2016

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	9:57 p.m., regarding blood work that was to be obtained on 3-21-16. The next entry, dated 3-27-16 at 3:00 a.m., indicated the resident's physician contacted the facility to "continue to monitor for repertory [sic] distress. If respirations fall below 15, then look at sending resident out to hospital for evaluation. Let resident rest today in bed. Encourage water. Call if any change in status." An entry on 3-27-16 at 6:04 a.m., indicated resident was monitored with vital signs and with the resident being groggy, but able to respond to staff. An entry on 3-27-16 at 10:21 a.m., indicated the attending physician was contacted related to the resident being "verbally unresponsive, B/P 109/53, T 97.2 ax, O-2 [sat] 92 [%] RA, P 62 RR 14, Pupils unresponsive to light." It indicated an order was received to send the resident to an area emergency room for evaluation and treatment and left the building at 10:17 a.m. via ambulance transport. In an interview with LPN #1 on 4-18-16 at 12:05 p.m., she was queried if she was aware of any issues with medication errors with Resident #B in the past month. She explained she would need to review his clinical record as she had been absent from work for a period of time in the last month. She indicated, upon		ofIndiana—including the administration of medications. It must be noted that Resident #B returnedto facility shortly after evaluation at the ER. Upon his return, the Resident was back tobaseline and has not experienced any further issues subsequent to this event. 2.To ensure thatthe facility only hires ***"qualified"*** nurses, the followingpre-employment screenings are conducted: license verification; criminal background check; reference checks. This has been a long standing practice of thefacility. All of the aforementionedpre-employment screenings were conducted for R.N. # 3. 3. R.N. # 3 was in orientation at the time ofthis incident. Although she wasobviously ***qualified to administer medications,*** she erred in judgementwhen she chose to proceed with the medication pass without the supervision orconsent of her preceptor. Neither thepreceptor nor any other member of the facility staff could have predicted thatR.N. # 3 would have independently decided to proceed with the medication passwithout the supervision of the preceptor. Said error in the judgment of R.N. # 3 resulted in the medication errorin question. R.N.# 3 was suspended at the time of occurrence, pending an investigation of thisincident. R.N.	

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	review of the clinical record, it appeared he had no such event. She continued, that he did have a past history of fluctuating blood pressure readings, "looks like that was the case," in relation to him being sent out to the emergency room on 3-27-16. In an interview with the Administrator on 4-18-16 at 1:25 p.m., she indicated Resident #B "did have a medication error. He received the wrong medications." In an interview with LPN #2 on 4-19-16 at 11:23 a.m., she indicated on the evening of 3-26-16, she was orienting a new nurse, RN #3. She indicated she was observing RN #3 with the entire bedtime medication pass. "Instructed [her] to get [Resident #C]'s blood sugar and get his meds ready while I went to check on two other residents. When I stepped back in the hall, she [RN #3] was gone and I heard her in [name of Resident #B]'s room. [When I got to his room], she was bent over and ready to give him insulin, Lantus, and I stopped her. [Name of Resident #B] does not receive insulin. Saw an empty med cup. She gave [name of Resident #C]'s oral meds to [name of Resident #B]...[Upon notification to the weekend supervisor], I was told by my supervisor not to document anything in		# 3 opted to resign herposition: she never returned to work atthis facility. Noother Residents were impacted by this incident, as the preceptor had remainedwith R.N. # 3, except during the brief time that the incident occurred. Asa result of this incident, the content of the Orientation Manual for Nurses hasbeen augmented to include an acknowledgement which will require the signatureof the orientee. Said acknowledgementwill mandate that during the orientation process, medications may not be givenwithout the direct supervision of the preceptor. The facility's Quality Assurance Nurseconducts the initial orientation for all newly hired licensed nurses, prior toallowing these individuals to begin orientation on the nursing units. The Quality Assurance Nurse will beresponsible for the presentation of this form and procuring a signature on the same. Pharmacy and Nursing management staff will conduct random med pass observations weekly x six months. Any identified errors will be given the Quality Assurance Nurse. 4.As a QualityAssurance measure, the Quality Assurance Nurse will review this topic during the facility's monthly Quality Assurance Meetings for the next six months. At the end of the six month period, the Quality Assurance Committee may elect	

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	the computer [nursing progress notes], just do a hand-written note about the incident." She indicated shortly after speaking with her supervisor, she received a call from the Assistant Director of Nursing to inquire about the incident. She indicated the physician and family were also notified of the incident, and passed along information to the next shift as to the incident and the physician's order to continue to monitor the resident closely. "I just wish she would have waited for me like I told her and to ask if she wasn't sure which resident was which, if she wasn't sure." Review of a "Medication Incident Report," dated 3-26-16 and signed by LPN #2, indicated on 3-26-16 at 9:30 p.m., Resident #B received "Norco [used for narcotic pain reliever], Gabapentin [used for neuropathic pain], Depakote [used for mood stabilization], Sinoment [sic] [used for Parkinson's disease], Lipitor [used for hyperlipidemia], Flomax [used for benign prostate hypertrophy]" related to "Nurse administered medication to the wrong resident." Resident #C's recapitulation orders for April, 2016 indicated his oral medications due for 9:00 p.m., or bedtime were the following medications:		to end the monthly review of this topic if 100% compliance is achieved.	

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	-Depakote 125 mg (milligrams) and Depakote 250 mg, 3 tabs, to equal a total of 875 mg. -Gabapentin 600 mg. -Sinemet CR (continuous release formula) 50/200 mg. -Lipitor 40 mg. -Flomax 0.4 mg. -Norco 5/325 mg every four hours by mouth for pain. In review of Resident #B's recapitulation orders for April, 2016, he was not ordered to receive any of the medications he received in error. Review of the ambulance company's report of the transportation of Resident #B from the facility to the area emergency room, dated 3-17-16, indicated at 10:16 a.m., he was initially found to be "responsive only to verbal stimuli...pupils pinpoint" with a respiratory rate of 12 breaths per minute. In indicated he was administered Narcan (used as an opioid antagonist) 0.4 mg via IV at 10:24 a.m., with the resident than able to state his name and date of birth, but "continued drowsy." Review of the emergency room visit documentation, dated 3-27-16, indicated the resident had an "accidental drug ingestion," and was unresponsive upon			

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	the arrival of the EMS (emergency medical services) staff to the facility. "But improved with IV [intravenous] Narcan. Per brother, back to baseline. Labs showed opiates in UDS [urine drug screen]...Pt [patient] is stable and plan to return back to nursing home..." On 4-18-16 at 2:05 p.m., the Administrator provided a copy of a policy entitled, "Medication and Treatment Incidents." This policy had a revision date of 9-15-15 and was indicated to be the current policy utilized by the facility. This policy indicated, "Purpose: To safeguard the Resident from recurrent medication and treatment incidents. Policy: Medication/Treatment incidents are to be reported to the physician and responsible party/family member. A Medication/Treatment incident report are to be completed by the individual noting the error. Medication errors will be reported to ISDH if treatment beyond ER visit required...The Resident is to be observed for adverse reaction to the error. Documentation must be thorough and change in condition reported to the physician. Necessary in-service/re-education of involved individuals and/or all licensed/qualified nursing staff shall be conducted based upon the cause, nature and extent of the error..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	This Federal tag relates to Complaint IN00197728. 3.1-25(b)(2) 3.1-25(b)(7) 3.1-25(b)(9) 3.1-48(c)(2)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure a medication error for 1 of 3 residents in a sample of 3 reviewed for medication errors was documented in the resident's clinical record. (Resident #B)	F 0514	1.Resident B's clinical record updatedwith late entry note to reflect the wrong medication administered. Facility policy will be updated to reflect the need for documentation of medication errors in the Resident clinical record.	05/11/2016

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	Findings include: Resident #B's clinical record was reviewed on 4-18-16 at 10:20 a.m. It indicated his diagnoses included, but were not limited to atrial fibrillation, atherosclerotic heart disease, high blood pressure, diabetes and vascular dementia. Review of Resident #B's nursing progress notes indicated an entry on 3-18-16 at 9:57 p.m., regarding blood work that was to be obtained on 3-21-16. The next entry, dated 3-27-16 at 3:00 a.m., indicated the resident's physician contacted the facility to "continue to monitor for repertory [sic] distress. If respirations fall below 15, then look at sending resident out to hospital for evaluation. Let resident rest today in bed. Encourage water. Call if any change in status." An entry on 3-27-16 at 6:04 a.m., indicated resident was monitored with vital signs and with the resident being groggy, but able to respond to staff. An entry on 3-27-16 at 10:21 a.m., indicated the attending physician was contacted related to the resident being "verbally unresponsive, B/P 109/53, T 97.2 ax, O-2 [sat] 92 [%] RA, P 62 RR 14, Pupils unresponsive to light." It indicated an order was received to send the resident to an area emergency room		2.Records of any Medication Errors within the past 30 days will be reviewed to ensure appropriate documentation is secured. 3.Facility policy will be updated toreflect the need for documentation in clinical record. Currentlicensed/qualified nursing staff shall be educated as to the revised policy.Newly hired licensed/qualified nursing staff shall be advised as to the policy. 4.The Quality Assurance Nurse will monitor Medication Incident reports to ensure a corresponding entry in Resident Clinical Record. Should non-compliance be noted, immediate corrective action shall be taken. During monthly facility Quality Assurance Meetings, the QA nurse will bring any identified deficit practices and corrective actions taken for six months . At the end of six monthsperiod the Quality Assurance Committee may elect to end the monthly review if100% compliance is achieved.	

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	for evaluation and treatment and left the building at 10:17 a.m. via ambulance transport. In an interview with LPN #1 on 4-18-16 at 12:05 p.m., she was queried if she was aware of any issues with medication errors with Resident #B in the past month. She explained she would need to review his clinical record as she had been absent from work for a period of time in the last month. She indicated, upon review of the clinical record, it appeared he had no such event. She continued, that he did have a past history of fluctuating blood pressure readings, "looks like that was the case," in relation to him being sent out to the emergency room on 3-27-16. In an interview with the Administrator on 4-18-16 at 1:25 p.m., she indicated Resident #B "did have a medication error. He received the wrong medications." In an interview with LPN #2 on 4-19-16 at 11:23 a.m., she indicated on the evening of 3-26-16, she was orienting a new nurse, RN #3. She indicated she was observing RN #3 with the entire bedtime medication pass. "Instructed [her] to get [Resident #C]'s blood sugar and get his meds ready while I went to check on two			

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	other residents. When I stepped back in the hall, she [RN #3] was gone and I heard her in [name of Resident #B]'s room. [When I got to his room], she was bent over and ready to give him insulin, Lantus, and I stopped her. [Name of Resident #B] does not receive insulin. Saw an empty med cup. She gave [name of Resident #C]'s oral meds to [name of Resident #B]...[Upon notification to the weekend supervisor], I was told by my supervisor not to document anything in the computer [nursing progress notes], just do a hand-written note about the incident." She indicated shortly after speaking with her supervisor, she received a call from the Assistant Director of Nursing to inquire about the incident. She indicated the physician and family were also notified of the incident, and passed along information to the next shift as to the incident and the physician's order to continue to monitor the resident closely. "I just wish she would have waited for me like I told her and to ask if she wasn't sure which resident was which, if she wasn't sure." In an interview with the Administrator on 4-18-16 at 2:05 p.m., she indicated there should have been an entry into Resident #B's nursing notes regarding the medication error.			

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	Review of a "Medication Incident Report," dated 3-26-16 and signed by LPN #2, indicated on 3-26-16 at 9:30 p.m., Resident #B received "Norco [used for narcotic pain reliever], Gabapentin [used for neuopathic pain], Depakote [used for mood stabilization], Sinoment [sic] [used for Parkinson's disease], Lipitor [used for hyperlipidemia], Flomax [used for benign prostate hypertrophy]" related to "Nurse administered medication to the wrong resident." Resident #C's recapitulation orders for April, 2016 indicated his oral medications due for 9:00 p.m., or bedtime were the following medications: -Depakote 125 mg (milligrams) and Depakote 250 mg, 3 tabs, to equal a total of 875 mg. -Gabapentin 600 mg. -Sinemet CR (continuous release formula) 50/200 mg. -Lipitor 40 mg. -Flomax 0.4 mg. -Norco 5/325 mg every four hours by mouth as needed for pain. In review of Resident #B's recapitulation orders for April, 2016, he was not ordered to receive any of the medications he received in error.			

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	In interview with the Director of Nursing on 4-19-16 at 3:50 p.m., she indicated, "Anywhere I have ever worked, we were always told not to document in the nursing notes any incident, such as a medication error. Is there a specific regulation that says we are to document it in the chart?" She indicated the "Medication Incident Report," is not a part of the resident's clinical record, but is a internal document for the facility. On 4-18-16 at 2:05 p.m., the Administrator provided a copy of a policy entitled, "Medication and Treatment Incidents." This policy had a revision date of 9-15-15 and was indicated to be the current policy utilized by the facility. This policy indicated, "Purpose: To safeguard the Resident from recurrent medication and treatment incidents. Policy: Medication/Treatment incidents are to be reported to the physician and responsible party/family member. A Medication/Treatment incident report are to be completed by the individual noting the error. Medication errors will be reported to ISDH if treatment beyond ER visit required...The Resident is to be observed for adverse reaction to the error. Documentation must be thorough and change in condition reported to the physician. Necessary in-service/re-education of involved			

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	individuals and/or all licensed/qualified nursing staff shall be conducted based upon the cause, nature and extent of the error..." This Federal tag relates to Complaint IN00197728. 3.1-25(b)(2) 3.1-25(b)(9) 3.1-50(a)(1) 3.1-50(a)(2)			
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (g) The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (D) major accidents. This state rule was not met as evidenced	F 9999	1. Administrator received educational instructionby the ISDH surveyor on 4-19-16. Administrator was instructed that the use of Narcan by EMT's was treatment beyond an ER visit and thus constituted a reportable incident. 2.There were no other significant mederrors. This was an isolated eventinvolving only Resident # B. 3.With the additional educationprovided by ISDH surveyor. Administrator and Director of Nursing both aware that use of Narcan constitutes a reportable incident. 4.The Quality Assurance Nurse will monitor for the use of Narcan and/or other procedures which	05/11/2016

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	by: Based on interview and record review, the facility failed to report a medication error to the Indiana State Department of Health (ISDH) as an unusual occurrence in which a resident was given multiple incorrect medications, resulting in the resident becoming somnolent and unresponsive and requiring emergent care with the use of a medication to reverse the effects of the unresponsiveness for 1 of 3 residents reviewed for the receipt of incorrect medications in a sample of 3. (Resident #B) Findings include: In an interview with the Administrator on 4-18-16 at 1:25 p.m., she indicated Resident #B "did have a medication error. He received the wrong medications." In an interview with LPN #2 on 4-19-16 at 11:23 a.m., she indicated on the evening of 3-26-16, she was orienting a new nurse, RN #3. She indicated she was observing RN #3 with the entire bedtime medication pass. "Instructed [her] to get [Resident #C]'s blood sugar and get his meds ready while I went to check on two other residents. When I stepped back in the hall, she [RN #3] was gone and I		would be consideredtreatment beyond an ER visit. Quality Assurance Nurse will review continued compliance during the facility's monthlyQuality Assurance Meetings for the next six months. At the end of the six month period, theQuality Assurance Committee may elect to end the monthly review of this topicof 100% compliance is achieved.	

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	heard her in [name of Resident #B]'s room. [When I got to his room], she was bent over and ready to give him insulin, Lantus, and I stopped her. [Name of Resident #B] does not receive insulin. Saw an empty med cup. She gave [name of Resident #C]'s oral meds to [name of Resident #B]." Review of a "Medication Incident Report," dated 3-26-16 and signed by LPN #2, indicated on 3-26-16 at 9:30 p.m., Resident #B received "Norco [used for narcotic pain reliever], Gabapentin [used for neuopathic pain], Depakote [used for mood stabilization], Sinoment [sic] [used for Parkinson's disease], Lipitor [used for hyperlipidemia], Flomax [used for benign prostate hypertrophy]" related to "Nurse administered medication to the wrong resident." Resident #C's recapitulation orders for April, 2016 indicated his oral medications due for 9:00 p.m., or bedtime were the following medications: -Depakote 125 mg (milligrams) and Depakote 250 mg, 3 tabs, to equal a total of 875 mg. -Gabapentin 600 mg. -Sinemet CR (continuous release formula) 50/200 mg. -Lipitor 40 mg.			

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	-Flomax 0.4 mg. -Norco 5/325 mg every four hours by mouth for pain. In review of Resident #B's recapitulation orders for April, 2016, he was not ordered to receive any of the medications he received in error. Review of the ambulance company's report of the transportation of Resident #B from the facility to the area emergency room, dated 3-17-16, indicated at 10:16 a.m., he was initially found to be "responsive only to verbal stimuli...pupils pinpoint" with a respiratory rate of 12 breaths per minute. In indicated he was administered Narcan (used as an opioid antagonist) 0.4 mg via IV at 10:24 a.m., with the resident than able to state his name and date of birth, but "continued drowsy." Review of the emergency room visit documentation for Resident #B, dated 3-27-16, indicated the resident had an "accidental drug ingestion," and was unresponsive upon the arrival of the EMS (emergency medical services) staff to the facility. "But improved with IV [intravenous] Narcan. Per brother, back to baseline. Labs showed opiates in UDS [urine drug screen]...Pt [patient] is stable and plan to return back to nursing			

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	home..." In interview with the Administrator on 4-18-16 at 3:40 p.m., she indicated, "I did not report the issue [medication error] to ISDH, but I did consider it. I guess I just didn't consider the use of the Narcan." In an interview with the Executive Director on 4-19-16 at 3:50 p.m., she indicated, "We did review if the med error should be reported to ISDH. We thought we were following the state guidelines because they really did nothing in ER much beyond observation. I guess we didn't consider the Narcan." This Federal tag relates to Complaint IN00197728. 3.1-(g)(1)(D)			