

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155616	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/20/2014
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NAME OF PROVIDER OR SUPPLIER ROBERT E LEE	STREET ADDRESS, CITY, STATE, ZIP CODE 201 E ELM ST NEW ALBANY, IN 47150
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F000000	<p>This visit was for the Investigation of Complaints IN00145604 and IN00153697.</p> <p>Complaint IN00153697 - Substantiated. Federal/state deficiencies related to the allegations are cited at F333.</p> <p>Complaint IN00145604 - Unsubstantiated due to lack of evidence.</p> <p>Survey dates: August 18, 19 and 20, 2014</p> <p>Facility number: 001145 Provider number: 155616 AIM number: 200120200</p> <p>Survey team: Jennifer Carr, RN</p> <p>Census bed type: SNF/NF: 71 Residential: 16 Total: 87</p> <p>Census payor type: Medicare: 7 Medicaid: 52 Other: 28 Total: 87</p> <p>Sample: 4</p>	F000000	<p>PREPARATION AND/ OR EXECUTION OF THIS PLAN OF CORRECTION IN GENERAL OR THIS CORRECTIVE ACTION IN PARTICULAR, DOES NOT CONSTITUTE AN ADMISSION OR 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.</p> <p>The facility is requesting a Desk Review of compliance for this plan of correction.</p>	

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=D	<p>This deficiency also reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on August 27, 2014, by Brenda Meredith, R.N.</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 record review and interview, the facility failed to ensure that 1 resident (Resident B) was free of significant medication errors in that Resident B received Resident C's scheduled, ordered psychotropic and narcotic medications (Doxepin 75 mg, Depakote 2,250 mg, and Morphine Sulphate 60 mg) in error on 6/23/2014 for 1 of 4 residents reviewed for medication errors.</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 8/19/2014 at 11:00 a.m.</p>	F000333	<p>1. Resident B chose to go to another facility and did not return from the hospital.</p> <p>2. No other Residents were affected as no other medication errors occurred.</p> <p>3. The Nurse involved in the medication error received disciplinary action as well as immediate in-servicing related to Medication Administration, Resident Identification and Medication Errors and the significance of. All Nurses and QMAs were in-serviced immediately following the incident related to Medication Administration, Resident Identification and Medication</p>	09/08/2014

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	<p>Resident B was admitted to the facility on 6/17/2014 and discharged on 6/24/2014 following transfer to the Emergency Department for unresponsiveness. Admitting diagnoses included, but were not limited to, history of CVA (stroke) with right sided paralysis, bipolar disorder, anxiety, depression, insomnia, chronic renal failure, and drug dependence/abuse. The 6/17/2014 Admission Nursing Assessment indicated that Resident B was alert to person, place and time.</p> <p>Resident B's 6/17/2014 Psychoactive Medication Information, 6/2014 Physician's Orders, and Medication Administration Record (MAR) indicated that she was prescribed and received valproic acid (mood stabilizer), Buspar and Xanax (depression), and Prozac (depression). Additionally, she received Percocet 5/325 mg as needed for pain. The 6/2014 MAR indicated that Resident B received all scheduled daily medications as ordered on 6/23/2014. The most recent dose of Percocet 5/325 mg was administered on 6/22/2014 at 9:00 p.m.</p> <p>A 6/23/2014 3:55 p.m. Nurse's Note indicated, "Resident LOA [leave of absence] per private auto with friend's signout." A Release of Responsibility for</p>		<p>Errors and the significance of. Policies related to Medication Administration, Resident Identification and Medication Errors were reviewed and found to be appropriate. All Nurses and QMAs will be re-in-serviced to ensure appropriate understanding of the policies related to Medication Administration, Resident Identification and Medication Errors and the significance of.</p> <p>4. The DON and/or ADON will monitor 5 Nurses/QMAs during medication passes to ensure appropriate policies and procedures are followed and the staff can verbalize the policy and the importance of. Weekly x4 then Monthly x5. Any areas of concern will be addressed immediately. The results of the audits will be reviewed by the QA committee to assess for compliance, the need for policy revisions and/or further educational needs. Additional audit will be added as warranted by the QA review.</p>				

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	<p>Leave of Absence," dated 6/23/2014, indicated that Resident B left the facility at 3:55 p.m. The return date indicated "6/23." The return time was not indicated (blank).</p> <p>The 6/24/2014 7:00 a.m. Nurse's Note, signed by LPN #1, indicated, "...Medication error occurred [sic] with resident app. [approximately] 11 p.m. [Physician] called and notified - ordered to hold all of her night time meds for tonight only. See incident report and attached nurses note for complete report."</p> <p>LPN #1's written account of the incident ("attached nurses note" as indicated above) included, but was not limited to, the following:</p> <p>6/23/2014 at 10:30 p.m. "CNA on duty informs me that [Resident A] wants her evening meds. Informed CNA I would go there next. Gathered all of residents evening meds including 60 mg of ER MS Contin [extended-release morphine]. Walked to [room number] to find only 1 resident present, I explain her evening meds in detail and chat with her for a short time. Resident appears alert & [and] oriented."</p> <p>6/23/2014 at 11:00 p.m. "I am informed by [Resident A] that I mistakenly gave</p>			

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	<p>her evening medications to [Resident B], her roommate [sic]...[Resident B] reported no adverse effects. Vital signs: [stable]."</p> <p>6/23/2014 at 11:30 p.m. "[Physician] informs me to hold all of [Resident B's] scheduled meds and to monitor closely....He was informed of [Resident A's] scheduled meds as well as [Resident B's]."</p> <p>Additional assessments of Resident B were completed by LPN #1 on 6/24/2014 at 12:15 a.m., 12:45 a.m., 2:00 a.m., 4:00 a.m., and 5:45 a.m. Documentation repeatedly indicated that resident denied adverse effects from the medication error, aroused to speech, and was alert and oriented.</p> <p>LPN #1's Nurse's Notes final documentation on 6/24/2014 at 6:30 a.m. indicated, "QMA and LPN on duty for next shift are informed of my error and [physician's] order to hold evening meds, as well as to monitor closely."</p> <p>Subsequent 6/24/2014 Nurse's Notes indicated monitoring of Resident B at 7:30 a.m., 8:05 a.m., 9:50 a.m., 10:40 a.m., and 11:35 a.m., and indicated that Resident B required progressively "more effort" to rouse.</p>			

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	<p>6/24/2014 8:05 a.m. Physician's Telephone Order indicated, "Hold res [resident] AM [morning] meds r/t [related to] drowsiness."</p> <p>6/24/2014 1:35 p.m. Nurse's Notes indicated, "Called to res [resident's] room. Res has eyes closed. Will not rouse. Sternal rub performed [without] results. Called M.D., N/O [new order] noted, Give Narcan 0.4 mg/1 ml IM [intramuscularly]. Advise M.D. after administration."</p> <p>6/24/2014 1:40 p.m. Physician's Telephone Order indicated, "Narcan 0.4 mg/ml give IM [intramuscularly] now."</p> <p>6/24/2014 1:40 p.m. Nurse ' s Notes indicated, " Narcan 0.4 mg/ 1 mg given IM [intramuscularly].... "</p> <p>6/24/2014 2:05 p.m. Physician's Telephone Order indicated, "Send to [hospital] ER [Emergency Department] for eval [evaluation] & [and] tx [treatment]."</p> <p>6/24/2014 2:05 p.m. Nurse's Notes indicated, "VS [vital signs] 110/60 [blood pressure], 45 [pulse], 22 [respirations], 81% [oxygen saturation] on 3.5 LPM [liters per minute] [of</p>			

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	<p>oxygen] via N/C [nasal cannula]. O2 [oxygen] started at 1:40 p.m. Called MD...N/O [new order]...send to [hospital] for eval [evaluation] and tx [treatment]."</p> <p>6/24/2014 2:10 p.m. Nurse's Notes indicated, "EMS on site to transport resident to [hospital]..."</p> <p>The 7/1/2014 [hospital] Discharge Summary included, but was not limited to, the following:</p> <p>Admit Date indicated, "6/24/2014 14:34 [2:34 p.m.]"</p> <p>Admitting Diagnosis indicated, "Acute respiratory failure sec [secondary] to accidental opiate overdose."</p> <p>Discharge Diagnoses indicated, "Acute respiratory failure sec [secondary] to accidental opiate overdose, MRSA [methicillin-resistant staphylococcus aureus] bacteremia, and RUE [right upper extremity] cellulitis."</p> <p>Discharge Condition indicated, "Stable."</p> <p>The DON (Director of Nursing) indicated, "[The physician] didn't think her going to the hospital had anything to do with the med error...."</p>			

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	<p>A copy of Specific Procedures for All Medications Policy was provided by the DON, on 8/19/2014 at 12:00 p.m., and indicated, "....Identify resident before administering medication."</p> <p>This Federal tag relates to Complaint IN00153697.</p> <p>3.1-48(c)(2)</p>			