

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 05/02/2013
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NAME OF PROVIDER OR SUPPLIER  SANDERS GLEN	STREET ADDRESS, CITY, STATE, ZIP CODE 334 S CHERRY ST WESTFIELD, IN 46074
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R000000	<p>This visit was for the investigation of Complaint IN00128080.</p> <p>Complaint IN00128080: Substantiated. State residential deficiency related to the allegation is cited at R241.</p> <p>Survey date: 5/2/13</p> <p>Facility number: 005657 Provider number: 005657 AIM number: N/A</p> <p>Survey team: Janet Stanton, R.N., TC Gloria Bond, R.N.</p> <p>Census bed type: Residential--107 Total--107</p> <p>Census payor type: Other--107 Total--107</p> <p>Residential Sample: 5</p> <p>This state finding is cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed by Tammy Alley RN on May 6, 2013.</p>	R000000		
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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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R000241	<p>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.</p> <p>Based on interview and record review, the facility failed to ensure 1 resident's scheduled pain medication was administered according to the written physician's order, in that the resident was given 4 tablets of a narcotic pain medication instead of the 1 tablet ordered. This deficiency impacted 1 resident in a sample of 5 residents reviewed for pain medication. (Resident #E)</p> <p>Findings include:</p> <p>In an interview during the initial orientation tour on 5/2/13 at 10:00 A.M., RN #1 indicated 15 residents in the building were receiving either a scheduled or frequent PRN (as needed) pain medications.</p> <p>In an interview on 5/2/13 at 10:55 A.M., Resident #E indicated one evening about 2 weeks ago, RN #3 had given her 4 pain pills. When the resident told the nurse she didn't take 4 Vicodin, the nurse responded "Yes,</p>	R000241	<p>R241 Immediately, upon discovery of medication error, resident's physician, resident and resident's family were notified of four vicodin tablets having been administered and the staff are monitoring the resident for adverse effects. No adverse affects resulted. The identified resident's physician's order for pain medication, was re-written to enhance clarification of the dose. The identified resident's complete medication regime was provided to affected resident for reference during medication administration. Nursing staff will review each medication with resident during administration. The 2567 report indicated the affected resident stated she told nurse she didn't take four (4) vicodin, however, this statement is not consistent with the actual event , as stated by resident and family during the resident's Care Conference.All residents have the potential of being affected. Medication Administration Records were reviewed for all residents receiving scheduled medication to ensure order clarity and</p>	05/03/2013			

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	<p>you have to take your medicine." Later, LPN #2 came to her room and told the resident she was "over-dosed."</p> <p>In an interview on 5/2/13 at 11:15 A.M., LPN #2 indicated she had heard about only 1 medication error. She indicated the nurse (who made the error) was new and "just read the order wrong."</p> <p>The clinical record for Resident #E was reviewed on 5/2/13 at 11:30 A.M. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, diabetes, hypertension, arthritis, and macular degeneration. On 3/15/13, the resident returned to Sanders Glen after a stay at another facility to receive physical therapy following a fall and fracture of the shoulder.</p> <p>The April, 2013 physician recap (recapitulation) sheet listed an order, dated 3/15/13, for: "Vicodin 5/500 i po BID and i po at HS." The order was for a pain medication (5 milligrams of a narcotic medication--Hydrocodone, and 500 milligrams of Acetaminophen) one tablet by mouth twice a day and one tablet by mouth at bedtime. The medication was scheduled for 9 A.M., 1 P.M., and 9</p>		<p>compliance. No other residents were identified at this time. Identified nurse received additional training regarding medication administration including reading the medication administration record (MAR) and confirming the medication dose is administered as ordered. Medication administration by the individual nurse identified will be monitored for five residents per shift through for four weeks with no medication errors noted. Observation of medication administration by this nurse will be included in the facility monthly medication administration quality assurance review. General nurse orientation includes medication administration and reading of the MAR including verifying the medication order on the MAR and checking the dose prior to administration. Nurse orientation will be revised to include extended narcotic administration and dose calculation oversight during the orientation process. Director of Nursing will continue to monitor the orientation process and assure a satisfactory completion of a nurse's orientation to the nursing department. Quality Assurance monitoring of Medication Administration is included in the facility QA process with Medication administration being monitored monthly, utilizing the audit tool CMS 20056 (1/20/12). Results are reported through the</p>				

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	<p>P.M.</p> <p>A nurse's note, dated 4/19/13 at 11:00 P.M., indicated "Resident received Vicodin 5/500 iiiii [four] po at HS. Resident stable and monitored per M.D.[medical doctor] orders. On call M.D., [physician's name], gave orders to check resident's O2 SAT [oxygen saturation] and respirations every 15 minutes X [times] 3 hours (8:30 P.M.-11:30 P.M.) then every 30 minutes X 3 hours (11:30 P.M.-2:30 A.M.). To hold 9:00 A.M. Vicodin on 4/20/13. If O2 SATs less than 92% or respiration less than 16, resident to go to E.R. [emergency room]. Daughter, [daughter's name], was notified of incident and came to stay with resident this evening. Resident's O2 SATs have all been greater than 92% and respirations greater than 16 at all checks thus far. Last check 97%/O2 and respirations 20 at 10:45 P.M. Resident alert and oriented and stable with no lethargy. BP [blood pressure] 110/57, P [pulse] 60, T [temperature] 97.9. Continue to monitor through night. On-call nurse notified of incident."</p> <p>In an interview on 5/2/13 at 2:40 P.M., the Director of Nursing indicated the nurse who made the medication error only worked part-time, and had called</p>		Quality Assurance process monthly for review and recommendations.				

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	<p>in earlier this day to indicate she would not be in to work. The Director of Nursing indicated today would still have been an orientation day.</p> <p>The completed Employee Records form indicated the nurse who made the error, RN #3, was hired on 3/27/13.</p> <p>The staffing schedule, as worked for April, 2013, indicated RN #3 worked only two days--4/11 and 4/15, before the medication error on 4/19/13.</p> <p>In an interview on 5/2/13 at 3:15 P.M., RN #3 described the incident saying she "saw the order on the Medication Administration Record and thought it said 4." She gave the medication and left the room. She did not indicate the resident had questioned the number of pills. The nurse indicated she did not catch the error. During the end-of-shift drug count reconciliation, another nurse, LPN #4, asked her "You gave 4?" RN #3 indicated she did not see the "Directions for Usage" listing the medication dosage at the top of the "Controlled Drug Administration Record," which was used to sign out Schedule II/narcotic drugs. The "Controlled Drug Administration Record" for the Vicodin listed the</p>						

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	<p>"Directions for Usage" for this resident as "i [one] BID and i HS."</p> <p>R.N. #3 indicated she did not question the dosage because she had seen several patients (in an acute care hospital setting) receive 4 tablets of a pain medication. She indicated these were younger people with fibromyalgia or arthritis, and were obese. When reviewing the order on the April 2013 Medication Administration Record, she indicated she did not remember how she saw a "4" for the number of tablets to give.</p> <p>A summary of a care conference meeting with facility staff, the resident and family members on 4/24/13 at 10:00 A.M. was provided by the Director of Nursing. The summary included, but was not limited to, the following:</p> <p>"... Nurse administering medication was [RN #3]. [Nurse's name] is new to SG [Sanders Glen], but 20+ years of nursing experience. Shared with group that a background check was completed on [RN #3], references (professional &amp; personal) were checked, licensed researched and verified. [RN #3] indicated she interpreted the MAR [Medication Administration Record] to administer</p>						

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	<p>4 tablets opposed to 1. [RN #3] has experience working in a hospital setting and indicated she did not think 4 tablets was highly unusual as she often had administered dosages similar and stronger. [Director of Nursing] re-trained and re-educated [RN #3] regarding this resident's medication regime and also familiarized her with the Assisted Living setting and discussed the acuity levels based on the health care setting. Orders for [Resident #E] were verified and re-written to ensure error does not happen again...."</p> <p>This State Residential tag relates to Complaint IN00128080.</p>			