

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2016
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NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00197313 .</p> <p>Complaint IN00197313 - Substantiated. Federal/State deficiencies related to the allegations are cited at F281 and F333.</p> <p>Survey dates: April 14 and 15, 2016.</p> <p>Facility number: 011596 Provider number: 155769 AIM number: 200901690</p> <p>Census bed type: SNF: 34 SNF/NF: 23 Total: 57</p> <p>Census payor type: Medicare: 32 Medicaid: 7 Other: 18 Total: 57</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 11474 on April 18,</p>	F 0000	F 0000Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the Complaint Survey (IN00197313) on April 15, 2016. Please accept this plan of correction as the providers credible allegation of compliance.	

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 0281 SS=G Bldg. 00	<p>2016.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to ensure residents were provided patient care in accordance with professional standards for 1 of 3 residents who was reviewed for admission medication order transcription. (Resident C)</p> <p>Findings include:</p> <p>The clinical record of Resident C was reviewed on 4/14/16 at 9:00 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, osteomyelitis and non pressure ulcer on the left foot.</p> <p>Review of the hospital discharge instructions, dated 4/1/16, indicated Resident C had been discharged on the following medications: acetaminophen (analgesic medication) 325 mg every 4 hours as needed for pain and/or mild fever, apixaban (anticoagulant medication) 2.5 mg twice daily, atrovastatin (antilipemic medication) 40</p>	F 0281	<p>F 281</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #C correct orders were received from the hospital. Medical Director reviewed diagnosis and medications and verified this residents orders. Resident is receiving the correct medications.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review the medical record of all residents admitted in the last 14 days to ensure the medications being administered are as ordered for this resident by the MD.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or</p>	04/30/2016

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	<p>mg at bed time, calcium 600+vitamin D (supplement) once daily, cephalixin (antibiotic medication) 500 mg twice daily, digoxin (inotropic medication) 125 mcg once daily (hold if heart rate less than 60), hydrochlorothiazide-lisinopril (antihypertensive medication) 12.5-20 mg once daily, hydrocodone-acetaminophen (analgesic medication) 5 mg - 325 mg every 4 hours as needed for pain, methotrexate (antineoplastic medication) 2.5 mg once daily, prednisone (corticosteroid medication) 5 mg once daily and sildenafil (pulmonary vasodilator medication) 50 mg once daily.</p> <p>Review of the hospital discharge medication reconciliation record, dated 4/1/16, indicated the facility sent the following medication orders electronically to the pharmacy: albuterol (bronchodilator medication) 2.5 mg/3 ml inhalation solution every 4 hours as needed for wheezing, alprazolam (antianxiety medication) 0.5 mg 3 times a day as needed for anxiety, amlodipine (antianginal medication) 10 mg once daily, calcium carbonate (antacid medication) 600 mg once daily, cholecalciferol (Vitamin D3) 2,000 Intl (international) Units once daily, dicyclomine (anticholinergic medication) 10 mg before meals,</p>		<p>designee will re-educate the Licensed Nurses on the following campus expectation: 1). All admission orders received are to be verified, including review that the medication order transcriptions are for the correct resident. 2). Admission checklist audit tool to include documentation that the orders received have been verified, including review that the medication order transcriptions are for the correct resident.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits and /or observations for all new admissions will be conducted by the DHS or designee 2 times per week times 8 weeks, then 5 residents monthly times 4 months to ensure compliance: 1). All admission orders received have been verified, including review that the medication order transcriptions are for the correct resident. 2). Admission checklist audit tool is complete and includes documentation that the orders received have been verified, including review that the medication order transcriptions are for the correct resident.</p> <p>The results of the audit observations will be reported, reviewed and trended for</p>	

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	<p>diphenoxylate-atropine (antidiarrheal medication) 2.5 mg - 0.025 mg 4 times a day as needed for loose stools, docusate sodium (stool softer) 100 mg once daily, enoxaparin (anticoagulant medication) 40 mg subcutaneous every 24 hours, gabapentin (anticonvulsant medication) 300 mg 3 times daily, hydrocodone-acetaminophen (analgesic medication) 5 mg - 325 mg twice daily as needed for pain, imipramine (antidepressant medication) 150 mg at bed time, levothyroxine (thyroid hormone) 0.125 mg once daily, omeprazole (proton pump inhibitor medication) 20 mg once daily, paroxetine (antidepressant medication) 40 mg once daily, polyethylene glycol (laxative) 17 gm once daily and sodium bicarbonate (acid medication) 1,950 mg once daily. The medication reconciliation record had another hospital patient's name on the top and bottom of the pages. The medications listed were not linked to a diagnoses.</p> <p>Review of Resident C's MAR (Medication Administration Record) for April, 2016 indicated Resident C received the incorrect medications and failed to receive the correct medications from 4/1/16 through 4/4/16.</p> <p>Review of the nursing note, dated 4/4/16</p>		<p>compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>at 11:51 a.m., indicated Resident C was having episodes of "confusion and impulsiveness."</p> <p>Review of the nursing note, dated 4/4/16 at 1:11 p.m., indicated Resident C continued to have "confusion and impulsiveness."</p> <p>Review of the nursing note, dated 4/4/16 at 1:30 p.m., indicated Resident C remained confused and the family requested Resident C be sent to the emergency room for evaluation.</p> <p>During an interview on 4/14/16 at 1:00 p.m., LPN #7 indicated she had been the nurse on duty at the time of Resident C's admission on 4/1/16. LPN #7 indicated the hospital had sent the discharge paperwork with Resident C. "He (Resident C) came with the paperwork from the hospital. I didn't realize they were someone else's orders. I had the 3rd shift nurse check the written orders against the computer to make sure I put them in right."</p> <p>During an interview on 4/14/16 at 1:05 p.m., RN #8 indicated she had worked the third shift on 4/1/16 and had been asked by LPN #7 to verify the admission medication orders for Resident C. "She (LPN #7) had the admission orders by the</p>			

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	<p>computer and asked me to go through the orders and make sure they were entered right. I read the orders and verified them in the computer to make sure they were entered right." RN #8 indicated she did not notice the medication orders were for another hospital patient.</p> <p>During an interview on 4/14/16 at 10:43 a.m., LPN/Unit Manager #6 indicated on 4/4/16 orders for an unknown resident were found. "I searched admission dates and realized (Resident C) had been admitted on the same date. I compared the orders on the written orders to what was in the computer - they were the same. I told (Director of Nursing's name) and (physician's name). By this time he was already in the ER per family request. (DON's name) notified the hospital of the error, she also notified the family." LPN/Unit Manager #6 also indicated the verification of the medication orders should have been done on the same shift. "We have a nurse on each hall and she should have gotten one of them to verify the orders." LPN/Unit Manager #6 indicated the facility uses an admission check list that was to be completed with each admission to ensure all documentation had been completed. The admission check list was not kept as part of the clinical record and Resident C's admission checklist was no longer</p>			

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F 0333 SS=G Bldg. 00	<p>available. LPN/Unit Manager #6 also indicated nursing staff were educated on this process during orientation.</p> <p>During an interview on 4/14/16 at 2:03 p.m., the Clinical Consultant indicated the medication error had been reported to the State and nursing staff re-education had been initiated immediately. "All orders should be verified, including making sure it is the correct person." Requested policy for admission order transcription and verification. No policy was found.</p> <p>This federal tag relates to Complaint IN00197313.</p> <p>3.1-35(g)(1)</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 residents were free from significant medication errors resulting in a resident going to the emergency room for evaluation due to a change of mental status in 1 of 3 residents reviewed for medication</p>	F 0333	<p>F 333</p> <p>Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident #C correct orders were received from the</p>	04/30/2016			

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	<p>administration. (Resident C)</p> <p>Findings include:</p> <p>The clinical record of Resident C was reviewed on 4/14/16 at 9:00 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, osteomyelitis and non pressure ulcer on the left foot.</p> <p>Review of the hospital discharge instructions, dated 4/1/16, indicated Resident C had been discharged on the following medications: acetaminophen (analgesic medication) 325 mg every 4 hours as needed for pain and/or mild fever, apixaban (anticoagulant medication) 2.5 mg twice daily, atrovastatin (antilipemic medication) 40 mg at bed time, calcium 600+vitamin D (supplement) once daily, cephalixin (antibiotic medication) 500 mg twice daily, digoxin (inotropic medication) 125 mcg once daily (hold if heart rate less than 60), hydrochlorothiazide-lisinopril (antihypertensive medication) 12.5-20 mg once daily, hydrocodone-acetaminophen (analgesic medication) 5 mg - 325 mg every 4 hours as needed for pain, methotrexate (antineoplastic medication) 2.5 mg once daily, prednisone (corticosteroid medication) 5 mg once daily and</p>		<p>hospital. Medical Director reviewed diagnosis and medications and verified this residents orders. Resident is receiving the correct medications.</p> <p>Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review the medical record of all residents admitted in the last 14 days to ensure the medications being administered are as ordered for this resident by the MD.</p> <p>Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus expectation: 1). All admission orders received are to be verified, including review that the medication order transcriptions are for the correct resident. 2). Admission checklist audit tool to include documentation that the orders received have been verified, including review that the medication order transcriptions are for the correct resident.</p> <p>How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits</p>				

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	<p>sildenafil (pulmonary vasodilator medication) 50 mg once daily..</p> <p>Review of the hospital discharge medication reconciliation record, dated 4/1/16, indicated the facility sent the following medication orders electronically to the pharmacy: albuterol (bronchodilator medication) 2.5 mg/3 ml inhalation solution every 4 hours as needed for wheezing, alprazolam (antianxiety medication) 0.5 mg 3 times a day as needed for anxiety, amlodipine (antianginal medication) 10 mg once daily, calcium carbonate (antacid medication) 600 mg once daily, cholecalciferol (Vitamin D3) 2,000 Intl (international) Units once daily, dicyclomine (anticholinergic medication) 10 mg before meals, diphenoxylate-atropine (antidiarrheal medication) 2.5 mg - 0.025 mg 4 times a day as needed for loose stools, docusate sodium (stool softer) 100 mg once daily, enoxaparin (anticoagulant medication) 40 mg subcutaneous every 24 hours, gabapentin (anticonvulsant medication) 300 mg 3 times daily, hydrocodone-acetaminophen (analgesic medication) 5 mg - 325 mg twice daily as needed for pain, imipramine (antidepressant medication) 150 mg at bed time, levothyroxine (thyroid hormone) 0.125 mg once daily,</p>		<p>and /or observations for all new admissions will be conducted by the DHS or designee 2 times per week times 8 weeks, then 5 residents monthly times 4 months to ensure compliance:</p> <p>1). All admission orders received have been verified, including review that the medication order transcriptions are for the correct resident. 2). Admission checklist audit tool is complete and includes documentation that the orders received have been verified, including review that the medication order transcriptions are for the correct resident.</p> <p>The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.</p>				

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	<p>omeprazole (proton pump inhibitor medication) 20 mg once daily, paroxetine (antidepressant medication) 40 mg once daily, polyethylene glycol (laxative) 17 gm once daily and sodium bicarbonate (acid medication) 1,950 mg once daily. The medication reconciliation record had another hospital inpatient's name on the top and bottom of the pages. The medications listed were not linked to a diagnoses.</p> <p>Review of Resident C's MAR (Medication Administration Record) for April, 2016 indicated Resident C received these incorrect medications from 4/1/16 through 4/4/16 as follows: amlodipine 10 mg, three doses calcium carbonate 600 mg, three doses cholecalciferol 2,000 units, three doses dicyclomine 10 mg, nine doses docusate 100 mg, three doses enoxaparin 40 mg, three doses gabapentin 300 mg, nine doses imipramine 150 mg, two doses levothyroxine 0.125 mg, three doses omeprazole 20 mg, three doses paroxetine 40 mg, three doses polyethylene glycol 17 gm, three doses</p> <p>Review of Resident C's MAR (Medication Administration Record) for April, 2016 indicated the facility failed to provide Resident C the correct</p>			

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	<p>medications from 4/1/16 through 4/4/16 as follows:</p> <p>apixaban 2.5 mg, seven doses atorvastatin 40 mg, four doses digoxin 125 mcg, three doses hydrochlorothiazide-lisinopril 12.5 mg-20 mg, three doses methotrexate 2.5 mg, three doses prednisone 5 mg, three doses sildenafil 50 mg, eight doses</p> <p>Review of the nursing note, dated 4/4/16 at 9:53 a.m. indicated Resident C presented with clear speech and able to make needs and wants known.</p> <p>Review of the nursing note, dated 4/4/16 at 11:51 a.m., indicated Resident C was having episodes of "confusion and impulsiveness."</p> <p>Review of the nursing note, dated 4/4/16 at 1:11 p.m., indicated Resident C continued to have "confusion and impulsiveness."</p> <p>Review of the nursing note, dated 4/4/16 at 1:30 p.m., indicated Resident C remained confused and the family requested Resident C be sent to the emergency room for evaluation.</p> <p>Review of the nursing note, dated 4/4/16 at 8:38 p.m., indicated Resident C</p>			

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	<p>returned to the facility from the emergency room. "He was confused and in an altered mental status. EMT's had to transfer res [resident] to the bed with a 2 assist. Res did not come back with new orders. Nurse took vitals, WNL [within normal limits]. Nurse called (name of hospital) ER to get new orders. Nurse talked to nurse that took care of res during ER stay, they said they didn't have any new orders. This nurse talked to 3 other (name of hospital) employees, they wouldn't send over original orders or new orders. This nurse talked to a secretary and was told she would transfer nurse to the 9th floor where he (Resident C) stayed originally. This nurse was transferred to a pt [patient] room. This nurse tried to call back to (name of hospital) to talk to someone on the 9th floor. The charge nurse said she couldn't pull up his information because he had been discharged but she would try to get a hold of an employee in medical records. They were not available. The charge nurse called her supervisor. She then told this nurse, 'We don't feel comfortable giving original orders since your facility has been giving him wrong meds for several days.' This nurse then called on call nurse (name of nurse), (name of nurse) advised to call DON (name of DON). (Name of DON) said to print off the medication list that the res was taking</p>				

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	<p>during the hospital stay and call (name of physician) and go over each medication with him to see if he still wants the medication continued. This nurse then called (name of physician), (name of physician) said to hold all medication until he could be seen in the AM. Res was restless and confused through the night. He made several attempts to get up. Nurse was afraid res was too unsteady, and it would be harmful to apply pressure to left foot due to pressure ulcer. Bed alarm was placed for safety. Will continue to monitor."</p> <p>During an interview on 4/14/16 at 8:45 a.m., Resident C indicated the facility had given him the wrong medication and he had to be sent to the emergency room for evaluation. Resident C indicated he did not remember much about the incident. "It really knocked me pretty good."</p> <p>During an interview on 4/14/16 at 1:00 p.m., LPN #7 indicated she had been the nurse on duty at the time of Resident C's admission on 4/1/16. LPN #7 indicated the hospital had sent the discharge paperwork with Resident C. "He (Resident C) came with the paperwork from the hospital. I didn't realize they were someone else's orders. I had the 3rd shift nurse check the written orders</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155769	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2016
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NAME OF PROVIDER OR SUPPLIER MORRISON WOODS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 4100 N MORRISON RD MUNCIE, IN 47304
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	<p>against the computer to make sure I put them in right." LPN #7 indicated it had been "easier to wait for the third shift nurse" instead of getting a second shift nurse from another hall to verify the orders.</p> <p>During an interview on 4/14/16 at 1:05 p.m., RN #8 indicated she had worked the third shift on 4/1/16 and had been asked by LPN #7 to verify the admission medication orders for Resident C. "She (LPN #7) had the admission orders by the computer and asked me to go through the orders and make sure they were entered right. I read the orders and verified them in the computer to make sure they were entered right." RN #8 indicated she did not notice the medication orders were for another hospital patient.</p> <p>During an interview on 4/14/16 at 10:43 a.m., LPN/Unit Manager #6 indicated on 4/4/16 orders for an unknown resident were found. "I searched admission dates and realized (Resident C) had been admitted on the same date. I compared the orders on the written orders to what was in the computer - they were the same. I told (Director of Nursing's name) and (physician's name). By this time he (Resident C) was already in the ER per family request. (DON's name) notified the hospital of the error, she also notified</p>			

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	<p>the family." LPN/Unit Manager #6 also indicated the verification of the medication orders should have been done on the same shift. "We have a nurse on each hall and she should have gotten one of them to verify the orders."</p> <p>During an interview on 4/14/16 at 2:03 p.m., the Clinical Consultant indicated the medication error had been reported to the State and nursing staff re-education had been initiated immediately. "All orders should be verified, including making sure it is the correct person." Requested policy for admission order transcription and verification. No policy was found.</p> <p>This federal tag relates to Complaint IN00197313.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>			