

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155708	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/11/2013
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NAME OF PROVIDER OR SUPPLIER  HILLSIDE MANOR NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 E NATIONAL HWY WASHINGTON, IN 47501
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F000000	<p>This visit was for the Investigation of Complaint IN00131623.</p> <p>Complaint IN00131623 Substantiated - Federal/State deficiencies are cited at F333.</p> <p>Survey dates: July 10 and 11, 2013</p> <p>Facility number: 000303 Provider number: 155708 AIM number: 100287530</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF: 3 SNF/NF: 38 Total: 41</p> <p>Census payor type: Medicare: 6 Medicaid: 30 Other: 5 Total: 41</p> <p>Sample: 12</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC</p>	F000000	Please accept the following as our credible allegation of compliance. We are cordially requesting paper compliance to this issue as we had addressed the deficient practice the day it occurred. If you need supporting documentation to remedy this situation, please contact the facility and documents will be sent via email.	

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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	16.2.  Quality review completed on July 18, 2013, by Jodi Meyer, RN			

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F000333 SS=G	<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 interview and record review, the facility failed to ensure a significant medication error did not occur, in that MSIR 75 mg ( a narcotic pain medication) was administered instead of Lorazepam 5 mg, resulting in the resident being admitted to the hospital and receiving Narcan (to reverse a drug overdose), for 1 of 12 residents reviewed for medication orders, in a sample of 12. Resident A</p> <p>Findings include:</p> <p>1. On 7/10/13 at 8:45 A.M., the Director of Nursing [DON] provided a "Medication Error Report," dated 6/23/13. The report included: "...Medication Given, MSIR, Dosage given, 75 mg...What was Physician's Order? Lorazepam 5 mg...Reason for making error: Failure to triple check Medication Cards [with] Medication Adminsitration Record. Could the error have endangered the life or welfare of the patient? Yes. Explain: Respiration decreased or ceasing. What was the actual effect of the error made on the patient? Respirations were found to be</p>	F000333	<p>F – 333</p> <p>The corrective action taken for those residents found to be affected by the deficient practice is that</p> <p>Resident A's physician was notified immediately and new orders received to administer Narcan and transported to Hospital ER. LPN # 1 was counseled on the error.</p> <p><i>The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that</i></p> <p>All residents have the potential to be affected. Facility policy was updated regarding administrating medication. All nurses and QMA will be checked off on a medication pass review to ensure deficient practice doesn't occur in the future.</p> <p>The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that</p> <p>One on one in - services was conducted for all Nurses and QMA's on medications pass. All nurses and QMA will be checked off on a medication pass review to ensure deficient practice doesn't occur in the future</p> <p><i>The corrective action taken to monitor to assure performance to assure compliance through quality assurance is that</i></p> <p>A Medication Pass audit has been</p>	07/12/2013	

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	<p>[decreased] [and] O2 [oxygen] saturations [decreased] Required Narcan to be administer [sic] [and] sent to hospital for observation. How was the error discovered? During 7AM Medication Narc [narcotic] Count...What precautions can you take to prevent a similar error? Triple checking all medications with Medication Label to Medication Adminsitration Records, concentration of the '5' Rights to Medication Administration."</p> <p>During interview with the DON at that time, she indicated on 6/23/13, as LPN # 1 and LPN # 2 were counting the narcotics between shifts, they realized that MSIR 75 mg had been mistakenly given to Resident A instead of Lorazepam 5 mg. The DON indicated both of the medications were small, white pills, and the medication cards which held the pills were next to each other in the medication cart. The DON indicated Resident A was to receive 5 tablets of Lorazepam 5 mg, and instead received 5 tablets of MSIR 15 mg. The DON indicated LPN # 1 did not check the label on the medication card. The DON indicated LPN # 1 received verbal counseling related to the incident.</p>		<p>developed to ensure that proper technique is being following while administering medication. This tool will be completed by the DON/designee weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of the quality assurance tools will be reviewed at the quarterly Quality Assurance meeting to determine if additional action is warranted.</p> <p>Completion date: July 12, 2013</p>		

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	<p>On 7/10/13 at 9:40 A.M., during interview with LPN # 1, she indicated she was working on 6/23/13, and at approximately 4:30 A.M., she administered medication to Resident A. LPN # 1 indicated she remembered counting 5 tablets, and that the Lorazepam and MSIR "were almost exactly the same color and shape." LPN # 1 indicated the MSIR and Lorazepam cards were "right next to each other." LPN # 1 indicated she "guessed she didn't look at the label." LPN # 1 indicated she realized the error during the narcotic count with LPN # 2 during change of shift. LPN # 1 indicated they immediately stopped the count and went in to assess Resident A.</p> <p>On 7/10/13 at 9:50 A.M., during interview with LPN # 2, she indicated she was doing the narcotic count with LPN # 1 and noticed the MSIR was "short." LPN # 2 indicated Resident A had 5 extra Ativan, and they "knew immediately what had happened." LPN # 2 indicated she went to assess Resident A, and found her to be lethargic, with her pupils constricted and her respiratory rate at 9. LPN # 2 indicated they immediately started the resident on oxygen, contacted the physician, and called the ambulance.</p>				

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	<p>The clinical record of Resident A was reviewed on 7/10/13 at 10:30 A.M. Diagnoses included, but were not limited to, dementia and schizophrenia.</p> <p>A Minimum Data Set [MDS] assessment, dated 4/17/13, indicated the resident was unable to complete a brief interview for mental status, had a short-term and long-term memory problem, and was severely impaired in cognitive skills for daily decision-making.</p> <p>A Physician's order, dated 2/26/13 and on the June 2013 orders, indicated, "Lorazepam 1 mg [Ativan]...Take 5 tablets (5 mg) by mouth 2 times daily...5AM, 4PM." An order for the medication MSIR was not documented in the clinical record.</p> <p>A monthly Vital Sign record indicated the resident's respirations were 16-20 breaths a minute from January 2013-June 2013. Blood pressure readings recorded from that time period ranged from 99/61-136/74.</p> <p>Nurses notes included the following notations:</p> <p>6/23/13 at 7:45 A.M. (sic): "This nurse administered 75 mg of MSIR to res</p>			

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	<p>[resident] instead of 5 mg of Ativan. This was noticed while doing narc [narcotic] count [with] oncoming nurse. Phys [physician] was notified et [and] Narcan was ordered et given IM. Res movement slower but responsive. Phys. ordered res to [hospital] ER for observation...."</p> <p>6/23/12 at "7:00" [sic]: "VS [vital signs] 88/48 - R [respirations] 9 - P [pulse] 60 - SpO2 [oxygen reading] 84%. Pupils constricted. Res. lethargic, responds when spoken to [with] a glance et occasional smile. O2 placed on res @ 2L per NC [nasal cannula]. Res. saluating [sic] on bed small wet area noted. Res kicks leg slowly @ times. Awaiting EMS [emergency medical service] for transport."</p> <p>The resident was transferred to the hospital on 6/23/13 at 7:20 A.M.</p> <p>Emergency Department Nurses Notes included the following: "0753 [7:53 A.M.] - Arrived...Reportedly staff gave Pt [patient] MSIR 75 ml [sic] @ approx 0430 [4:30 A.M.], was to give Ativan 5 mg per report from N. Home [sic]. Pt. resp - 9...Pt. reportedly lethargic - upon arrival...pupils pinpoint...R-24...0855 [8:55 A.M.] Resp 7-10, Dr. notified...0917 [9:17</p>			
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	<p>A.M.] Narcan 0.4mg IVP [IV push]...0955 [9:55 A.M.] Resp 6-10, Reported to Dr, asleep does not arouse...1003 [10:03 A.M.] Narcan 0.4 ml IVP repeated...1100 [11:00 A.M.] No [change] Quiet R-10...1155 [11:55 A.M.] Transported to ICU."</p> <p>A hospital history and physical, dated 6/23/13, indicated, "...Reason for evaluation: Opiate overdose. History of Present Illness:...She apparently was given multiple doses of morphine inadvertently and was transferred because she was lethargic. She did receive two doses of Narcan .4 in the nursing home before, and then also received two dosed of Narcan .4 in the Emergency Room and she was subsequently admitted for observation. At present she is in the Intensive Care unit...Laboratory Data: Her urine drug screen was positive for benzo, opiates, and barbituates...Prognosis is guarded."</p> <p>2. On 7/10/13 at 2:45 P.M., the Director of Nursing provided the current facility policy on "Medication Administration," undated. The policy included: "...Prior to administration, the medication and dosage schedule on the resident's medication administration record [MAR] is compared with the medication</p>			

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	<p>label...Medications are administered in accordance with written orders of the attending physician...."</p> <p>This federal tag relates to Complaint IN00131623.</p> <p>3.1-25(b)(9)</p>			