

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155730	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/06/2011
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NAME OF PROVIDER OR SUPPLIER RIPLEY CROSSING	STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	<p>This visit was for the Investigation of Complaint IN00098005.</p> <p>Complaint IN00098005 - Substantiated. Federal/state deficiencies related to the allegation are cited at F281, F282, and F333.</p> <p>Survey date: October 6, 2011</p> <p>Facility number: 000420 Provider number: 155730 AIM number: 100266230</p> <p>Survey team: Diana Sidell, RN</p> <p>Census bed type: SNF/NF: 94 Residential: 10 Total: 104</p> <p>Census payor type: Medicare: 6 Medicaid: 70 Other: 28 Total: 104</p> <p>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F0000	The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation while continuing to provide quality of care to all residents.	

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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F0281 SS=D	<p>Quality review completed 10/14/11 by Jennie Bartelt, RN.</p> <p>The services provided or arranged by the facility must meet professional standards of quality. Based on record review and interview, the facility failed to provide services that met professional standards of quality in that one resident was administered another resident's medications. This affected 1 of 3 residents reviewed related to medication errors in 3 sampled. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's record was reviewed on 10/6/11 at 11:00 a.m. The record indicated Resident #A was admitted with diagnoses that included but were not limited to, high blood pressure, atrial fibrillation, congestive heart failure, breast cancer, history of stroke, thyroid problems, left femur fracture, diabetes mellitus, and gastroesophageal reflux disorder.</p> <p>Physician's admission orders dated 9/20/11 indicated the following orders for routine medications for Resident #A: - Levothyroxine 75 mcg (micrograms) by</p>	F0281	<p>What corrective actions will be accomplished? Resident will receive correct medications ordered to them by the physician Identify other residents with the potential to be affected. All residents have the potential to be affected What measures will be put into place to prevent reoccurrence? 1. Resident pictures will now include resident name before being transferred into the accuflo (EMAR) system to prevent the wrong picture being placed to the wrong resident 2. Nurses and QMAs in-serviced on the 5rights of medication administration 3. Nurses and QMAs observed for competency of medication administration 4. How the corrective actions will be monitored:</p> <p>1.First, the resident's picture is added to EMAR Profile by Medical Record Designee.</p> <p>2.Second, it will be verified by MDS nurse or DON to ensure the correct picture is the correct resident at the time picture is being added to profile.</p>	10/20/2011	

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	<p>mouth every day for hypothyroidism</p> <ul style="list-style-type: none"> <li>- Lasix 80 mg (milligrams) by mouth every day for congestive heart failure</li> <li>- Lasix 40 mg every evening for congestive heart failure</li> <li>- Glimepiride 1 mg 20 mg by mouth every day for diabetes</li> <li>- Metformin 500 mg by mouth twice a day for diabetes</li> <li>- Prilosec 20 mg by mouth every day for gastroesophageal disease</li> <li>- Hyzaar 100/12.5 by mouth every day for high blood pressure</li> <li>- Klor-con 20 mg by mouth every day as a supplement</li> <li>- Januvia 100 mg by mouth every day for diabetes</li> <li>- Prednisone 10 mg by mouth every day</li> <li>- Oscal 500 mg by mouth every day as a supplement</li> <li>- MVI (multivitamin) one daily by mouth as a supplement</li> <li>- Simvastatin 5 mg by mouth every bedtime for high blood lipids</li> <li>- Diltiazem 240 mg by mouth every bedtime for high blood pressure</li> <li>- Coumadin 2.5 mg by mouth every day for atria fibrillation</li> <li>- Singulair 10 mg by mouth every bedtime for chronic obstructive pulmonary disease</li> <li>- Symbicort (inhaler) one puff twice a day for chronic obstructive pulmonary disease</li> <li>- Fragmin 75000 units subq (injected under the skin) twice a day until INR</li> </ul>		<p>3. Third, the MDS nurse or DON will re-log in to the system to re-verify this is the correct picture with the correct resident and document the accuracy.</p> <p>5. This corrective action will be monitored by ADM or designee at time of admission x 6 months. This monitoring is ongoing and will be discussed with the Q.A. By what date the systemic changes will be completed. 10-20-11</p>		

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	<p>(International Normalization Ratio - test blood clotting) is between 2.0 - 3.0 - Colace 100 mg by mouth twice a day for decreased bowel motility.</p> <p>Nurse's notes dated 9/30/11 at 8:45 a.m. indicated: "...Res. (resident) had been given [medical record number of another resident] 8 am medications. MD notified &amp; says to monitor BP [blood pressure] regularly throughout the day. Res. LOA [leave of absence] @ 8 am for MD appt. [MD office phone number] notified &amp; spoke [with] a receptionist. Writer told woman on phone about medications &amp; ask if able to speak to office. Woman said, "I will let them know"...."</p> <p>A medication error report dated 9/30/11 included: "...Description of error (include name of medication, dose, route and times(s) administered) Res. received ASA 81 mg, (baby aspirin), Metoprolol 25 mg (blood pressure), Lisinopril 40 mg (blood pressure), Citalopram 10 mg (antidepressant), Plavix 75 mg (reduces chance of blood clots), Amiodarone 200 mg (heart medication)" and indicated the error was the medications were given to the wrong resident.</p> <p>An incident as reported to the ISDH (Indiana State Department of Health) indicated: Brief Description of Incident:</p>				

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	<p>Resident was given another resident's medication. Type of Injury/Injuries: Resident currently being monitored. Immediately Action Taken: Primary care physician &amp; family notified...."</p> <p>During an interview on 10/6/11 at 9:55 a.m., the Director of Nurses and Administrator indicated Resident A had been ill a few days prior to going to a follow up orthopedist appointment. While at the appointment, the facility discovered the medication error and reported it to the resident's primary care physician and to the orthopedist.</p> <p>A policy and procedure for "Medication Errors Prevention", with a last review date of 9/30/11, was provided by the Director of Nurses on 10/6/11 at 11:00 a.m. The policy indicated, but was not limited to: "Purpose: To administer medications correctly. Policy: Residents will be administered medications safely and accurately observing the Five Rights of administering medications: The right resident, the right drug, the right dose, the right time, the right route. Procedure: 1. All medications will be administered in the prescribed manner in accordance with prevailing statutes and current standard nursing practice...."</p> <p>"Fundamentals of Nursing" Third Edition</p>				

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F0282 SS=D	<p>indicated "Medication Delivery: Preparing and administering medications requires accuracy by the nurse...The nurse uses the following guidelines, the "five rights" of drug administration, to ensure safe drug administration: 1. The right drug 2. The right dose 3. the right client 4. The right route 5. The right time..."</p> <p>This federal tag is related to Complaint IN00098005.</p> <p>3.1-35(g)(1)</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure physician orders were followed for medication administration for 1 of 3 residents reviewed related ot medication errors in a sample of 3. (Resident #A)</p> <p>Findings include:</p>	F0282	<p>What corrective actions will be accomplished? Resident will receive correct medications ordered to them by the physician Identify other residents with the potential to be affected. All residents have the potential to be affected What measures will be put into place to prevent reoccurrence? 1. Resident pictures will now include resident</p>	10/20/2011	

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	<p>Resident #A's record was reviewed on 10/6/11 at 11:00 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, high blood pressure, atrial fibrillation, congestive heart failure, breast cancer, history of stroke, thyroid problems, left femur fracture, diabetes mellitus, and gastroesophageal reflux disorder.</p> <p>Physician's admission orders dated 9/20/11 indicated the following orders for routine medications:</p> <ul style="list-style-type: none"> <li>- Levothyroxine 75 mcg (micrograms) by mouth every day for hypothyroidism</li> <li>- Lasix 80 mg (milligrams) by mouth every day for congestive heart failure</li> <li>- Lasix 40 mg every evening for congestive heart failure</li> <li>- Glimepiride 1 mg 20 mg by mouth every day for diabetes</li> <li>- Metformin 500 mg by mouth twice a day for diabetes</li> <li>- Prilosec 20 mg by mouth every day for gastroesophageal disease</li> <li>- Hyzaar 100/12.5 by mouth every day for high blood pressure</li> <li>- Klor-con 20 mg by mouth every day as a supplement</li> <li>- Januvia 100 mg by mouth every day for diabetes</li> <li>- Prednisone 10 mg by mouth every day</li> <li>- Oscal 500 mg by mouth every day as a</li> </ul>		<p>name before being transferred into the accuflor (EMAR) system to prevent the wrong picture being placed to the wrong resident 2. Nurses and QMAs in-serviced on the 5rights of medication administration 3. Nurses and QMAs observed for competency of medication administration 4. How the corrective actions will be monitored:</p> <ol style="list-style-type: none"> <li>1.First, the resident's picture is added to EMAR Profile by Medical Record Designee.</li> <li>2.Second, it will be verified by MDS nurse or DON to ensure the correct picture is the correct resident at the time picture is being added to profile.</li> <li>3.Third, the MDS nurse or DON will re-log in to the system to re-verify this is the correct picture with the correct resident and document the accuracy.</li> <li>5. This corrective action will be monitored by ADM or designee at time of admission x 6 months. This monitoring is ongoing and will be discussed with the Q.A. By what date the systemic changes will be completed. 10-20-11</li> </ol>		

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	<p>supplement</p> <ul style="list-style-type: none"> <li>- MVI (multivitamin) one daily by mouth as a supplement</li> <li>- Simvastatin 5 mg by mouth every bedtime for high blood lipids</li> <li>- Diltiazem 240 mg by mouth every bedtime for high blood pressure</li> <li>- Coumadin 2.5 mg by mouth every day for atria fibrillation</li> <li>- Singulair 10 mg by mouth every bedtime for chronic obstructive pulmonary disease</li> <li>- Symbicort (inhaler) one puff twice a day for chronic obstructive pulmonary disease</li> <li>- Fragmin 75000 units subq (injected under the skin) twice a day until INR (International Normalization Ratio - test blood clotting) is between 2.0 - 3.0</li> <li>- Colace 100 mg by mouth twice a day for decreased bowel motility.</li> </ul> <p>Nurse's notes dated 9/30/11 at 8:45 a.m. indicated: "...Res. (resident) had been given [medical record number of another resident] 8 am medications. MD notified &amp; says to monitor BP [blood pressure] regularly throughout the day. Res. LOA [leave of absence] @ 8am for MD appt. [MD office phone number] notified &amp; spoke [with] a receptionist. Writer told woman on phone about medications &amp; ask if able to speak to office. Woman said, "I will let them know" ...."</p> <p>A medication error report dated 9/30/11</p>				

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	<p>included: "...Description of error (include name of medication, dose, route and times(s) administered) Res. received ASA 81 mg, (baby aspirin), Metoprolol 25 mg (blood pressure), Lisinopril 40 mg (blood pressure), Citalopram 10 mg (antidepressant), Plavix 75 mg (reduces chance of blood clots), Amiodarone 200 mg (heart medication)" and indicated the error was the medications were given to the wrong resident.</p> <p>An incident as reported to the ISDH indicated: Brief Description of Incident: Resident was given another residents medication. Type of Injury/Injuries: Resident currently being monitored. Immediately Action Taken: Primary care physician &amp; family notified...."</p> <p>During an interview on 10/6/11 at 9:55 a.m., the Director of Nurses and Administrator indicated Resident A had been ill a few days prior to going to a follow up orthopedist appointment. While at the appointment, the facility discovered the medication error and reported it to the resident's primary care physician and to the orthopedist.</p> <p>A policy and procedure for "Medication Errors Prevention", with a last review date of 9/30/11, was provided by the Director of Nurses on 10/6/11 at 11:00 a.m. The</p>				

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F0333 SS=D	<p>policy indicated, but was not limited to: "Purpose: To administer medications correctly. Policy: Residents will be administered medications safely and accurately observing the Five Rights of administering medications: The right resident, the right drug, the right dose, the right time, the right route. Procedure: 1. All medications will be administered in the prescribed manner in accordance with prevailing statutes and current standard nursing practice...4. Compare the medication label with the physician order...."</p> <p>This federal tag is related to Complaint IN00098005.</p> <p>3.1-35(g)(2)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a resident was free of any significant medication error in that one resident was given another resident's medications. This affected 1 of 3 residents reviewed related to medication errors in a sample of 3. (Resident #A)</p>	F0333	<p>What corrective actions will be accomplished? Resident will receive correct medications ordered to them by the physician Identify other residents with the potential to be affected. All residents have the potential to be affected What measures will be put into place to prevent</p>	10/20/2011	

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	<p>Findings include:</p> <p>Resident #A's record was reviewed on 10/6/11 at 11:00 a.m. The record indicated Resident #A was admitted with diagnoses that included, but were not limited to, high blood pressure, atrial fibrillation, congestive heart failure, breast cancer, history of stroke, thyroid problems, left femur fracture, diabetes mellitus, and gastroesophageal reflux disorder.</p> <p>Physician's admission orders dated 9/20/11 indicated the following orders for routine medications:</p> <ul style="list-style-type: none"> <li>- Levothyroxine 75 mcg (micrograms) by mouth every day for hypothyroidism</li> <li>- Lasix 80 mg (milligrams) by mouth every day for congestive heart failure</li> <li>- Lasix 40 mg every evening for congestive heart failure</li> <li>- Glimepiride 1 mg 20 mg by mouth every day for diabetes</li> <li>- Metformin 500 mg by mouth twice a day for diabetes</li> <li>- Prilosec 20 mg by mouth every day for gastroesophageal disease</li> <li>- Hyzaar 100/12.5 by mouth every day for high blood pressure</li> <li>- Klor-con 20 mg by mouth every day as a supplement</li> <li>- Januvia 100 mg by mouth every day for</li> </ul>		<p>reoccurrence? 1. Resident pictures will now include resident name before being transferred into the accuflo (EMAR) system to prevent the wrong picture being placed to the wrong resident 2. Nurses and QMAs in-serviced on the 5rights of medication administration 3. Nurses and QMAs observed for competency of medication administration 4. How the corrective actions will be monitored:</p> <ol style="list-style-type: none"> <li>1.First, the resident's picture is added to EMAR Profile by Medical Record Designee.</li> <li>2.Second, it will be verified by MDS nurse or DON to ensure the correct picture is the correct resident at the time picture is being added to profile.</li> <li>3.Third, the MDS nurse or DON will re-log in to the system to re-verify this is the correct picture with the correct resident and document the accuracy.</li> <li>5. This corrective action will be monitored by ADM or designee at time of admission x 6 months. This monitoring is ongoing and will be discussed with the Q.A. By what date the systemic changes will be completed. 10-20-11</li> </ol>		

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	<p>diabetes</p> <ul style="list-style-type: none"> <li>- Prednisone 10 mg by mouth every day</li> <li>- Oscal 500 mg by mouth every day as a supplement</li> <li>- MVI (multivitamin) one daily by mouth as a supplement</li> <li>- Simvastatin 5 mg by mouth every bedtime for high blood lipids</li> <li>- Diltiazem 240 mg by mouth every bedtime for high blood pressure</li> <li>- Coumadin 2.5 mg by mouth every day for atria fibrillation</li> <li>- Singulair 10 mg by mouth every bedtime for chronic obstructive pulmonary disease</li> <li>- Symbicort (inhaler) one puff twice a day for chronic obstructive pulmonary disease</li> <li>- Fragmin 75000 units subq (injected under the skin) twice a day until INR (International Normalization Ratio - test blood clotting) is between 2.0 - 3.0</li> <li>- Colace 100 mg by mouth twice a day for decreased bowel motility.</li> </ul> <p>Nurse's notes dated 9/30/11 at 8:45 a.m. indicated: "...Res. (resident) had been given [medical record number of another resident] 8 am medications. MD notified &amp; says to monitor Bp regularly throughout the day. Res. LOA @ 8am for MD appt. [MD office phone number] notified &amp; spoke [with] a receptionist. Writer told woman on phone about medications &amp; ask if able to speak to office. Woman said, "I will let them</p>				

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	<p>know" ...."</p> <p>A medication error report dated 9/30/11 included: "...Description of error (include name of medication, dose, route and times(s) administered) Res. received ASA 81 mg, (baby aspirin), Metoprolol 25 mg (blood pressure), Lisinopril 40 mg (blood pressure), Citalopram 10 mg (antidepressant), Plavix 75 mg (reduces chance of blood clots), Amiodarone 200 mg (heart medication)" and indicated the error was the medications were given to the wrong resident.</p> <p>An incident as reported to the ISDH (Indiana State Department of Health) indicated: Brief Description of Incident: Resident was given another resident's medication. Type of Injury/Injuries: Resident currently being monitored. Immediately Action Taken: Primary care physician &amp; family notified...."</p> <p>A Pharmacist statement included in the investigation of the medication error, and dated 9/30/11, (no time) indicated: "Compared what she received vs what she did not get that she was supposed to and considered her diagnoses she received Blood pressure meds X2, (Metoprolol and Lisinopril) she did not receive B/P meds X2 (Hyzaar and Diltiazem). Received Diabetic med, has DM (diabetes).</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155730	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/06/2011
NAME OF PROVIDER OR SUPPLIER  RIPLEY CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 WHITLATCH WAY MILAN, IN47031		
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	<p>Received heart med has AFib (atrial fibrillation). [The Pharmacist] feels [the] resident has comparable medications &amp; that minimal if any adverse effects would be the result."</p> <p>During an interview on 10/6/11 at 9:55 a.m., the Director of Nurses and Administrator indicated Resident A had been ill a few days prior to going to a follow up orthopedist appointment. While at the appointment, the facility discovered the med error and reported it to the resident's primary care physician and to the orthopedist.</p> <p>A policy and procedure for "Medication Errors Prevention," with a last review date of 9/30/11, was provided by the Director of Nurses on 10/6/11 at 11:00 a.m. The policy indicated, but was not limited to: "Purpose: To administer medications correctly. Policy: Residents will be administered medications safely and accurately observing the Five Rights of administering medications: The right resident, the right drug, the right dose, the right time, the right route. Procedure: 1. All medications will be administered in the prescribed manner in accordance with prevailing statutes and current standard nursing practice...."</p> <p>This federal tag is related to Complaint</p>				

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	IN00098005.  3.1-25(b)(9) 3.1-48(c)(2)				