

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/24/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00199101.</p> <p>Complaint IN00199101 - Substantiated. Federal/State deficiencies related to the allegations are cited at F333.</p> <p>Survey date: May 24, 2016</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Census bed type: SNF/NF: 134 Total: 134</p> <p>Census payor type: Medicare: 16 Medicaid: 95 Other: 23 Total: 134</p> <p>Sample: 3</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on May 26, 2016.</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</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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F 0333 SS=D Bldg. 00	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>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 resident received the correct dose of Phenobarbital (high risk medication used for seizures) and Clonazepam (medication used for seizures) and failed to ensure medication doses for Vimpat (seizure medication) and Clonazepam were not omitted from a residents drug regimen for 1 of 3 residents reviewed for medication administration. (Resident #D)</p> <p>Findings include:</p> <p>The clinical record for Resident #D was reviewed on 5/24/16 at 10:45 a.m. Diagnosis included, but was not limited to, epilepsy.</p> <p>The physician order, dated 3/25/16 and untimed, included, but was not limited to, the following: "...3/25/16...DC [discontinue] phenobarbital 64.8 [64.8</p>	F 0333	<p>It is the practice of Kindred Columbus to ensure that residents are free of any significant medication errors 1) The Director of Nursing has counseled and in-serviced thenursing staff involved in the dosing errors for Resident D as well as theprocedures for managing a medication error. 2) The Director of Nursing and her designees, have reviewedthe narcotic Medication Administration Records and the narcotic medication inthe Medication Carts to compare and assure correct doses are in place for eachresident receiving narcotic medications. This was completed on May 24, 2016 3) The Director of Nursing in-serviced the licensed staff onthe provision of pharmacy services including following physician orders to givethe correct dose of medication. TheStaff Development Coordinator will include information on the provision of</p>	06/14/2016

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	<p>milligrams] tab BID [two times a day]...Start phenobarbital 32.4 mg [milligrams]...2 tabs [64.8 milligrams]] in Morning [sic] [plus sign] [and] 3 tabs [97.2 milligrams] at HS [bedtime]...."</p> <p>The narcotic count sheet, dated 3/14/16, included, but was not limited to, the following: "...[Resident #D]...Phenobarbital 64.8 mg table [sic] [tablet] Give 1 tablet via g-tube 2 times a day for seizure disorder...Directions changed [handwritten on sheet]...Date...3/27/16...Time...9A [9:00 a.m.]...Amt [amount] Given...2...Qty [quantity] Remain...9...." The narcotic count sheet indicated Resident #D received 129.6 milligrams at 9:00 a.m. and should have only received 64.8 milligrams as indicated per the physicians order dated 3/25/16.</p> <p>The narcotic count sheet, dated 3/14/16, included, but was not limited to, the following: "...[Resident #D]...Phenobarbital 64.8 mg table [sic] [tablet] Give 1 tablet via g-tube 2 times a day for seizure disorder...D/C [handwritten on sheet]...Date...4/11/16...Time...2100 [9:00 p.m.]...Amt [amount] Given... [division sign] [1]...Date...4/20/16...Time...9p [9:00 p.m.]...Amt Given...[division sign] [1]...."</p>		<p>pharmacyservices including following physician orders as well as giving the correctdose of medication when orienting new licensed staff. The Director of Nursing, or her designee,will review new medication orders on a weekly basis to assure medications areadministered according to physician's order. The Pharmacy Consultant will continue to conduct monthly medicationreviews and provide a written report to the Director of Nursing for followthrough. Licensed staff and QualifiedMedication Aides have proven competency related to medication administration. 4) The Director of Nursing, or her designee, will monitorthrough observation, narcotic Medication Administration Record review andPharmacy Consultant Report review, at least monthly for three months, then atleast quarterly, to assure medications are administered according tophysician's orders. The Director ofNursing will report progress to the facility Performance Improvement Committee.</p>	

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	<p>The narcotic count sheet indicated Resident #D received 64.8 milligrams at 9:00 p.m. on 4/11/16 and 4/20/16 but should have received 97.2 milligrams as indicated per the physicians order dated 3/25/16.</p> <p>The narcotic count sheet, dated 4/5/16, included, but was not limited to, the following: "...[Resident #D]...Phenobarbital 32.4 mg table [sic] [tablet] Give 2 tablets (64.8 mg) via g-tube in the am [morning] and 3 tablets (97.2 mg) via g-tube at bedtime...Date...4/8/16...Time...9a [9:00 a.m.]...Amt [amount] Given...1...Date...4/18/16...Time...0900 [9:00 a.m.]...Amt [amount] Given...1...Date...4/25/16...Time...2250 [10:30 p.m.]...Amt [amount] Given...[2 dots over a vertical line with 2 horizontal lines underneath] [2]...."</p> <p>The narcotic count sheet, undated, included, but was not limited to, the following: "...[Resident #D]...Phenobarbital 32.4 mg Give 2 tab (64.8 mg) via GT [g-tube] in AM [morning] Give 3 tabs (97.2 mg) via GT @ [at] Bed time...Date...5/6 [5/6/16]...Time...9p [9:00 p.m.]...Dose Given...2...."</p> <p>The document titled, "Admission Orders</p>			

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	<p>Record", dated 12/13/14, included, but were not limited to, the following: "...Clonazepam 1 mg via G-tube...12P [12:00 p.m.]...Clonazepam 2 mg via G-tube q [every] AM [morning] [plus sign] [and] HS [bedtime]...."</p> <p>The narcotic count sheet, dated 2/22/16, included, but was not limited to, the following: "...[Resident #D]...Clonazepam 1 mg tablet...1 mg...Give 1 tablet via G-tube daily at 12 noon...Dx [diagnosis]: seizure disorder...Date...3/31 [3/31/16]...Time...9a [9:00 a.m.]...Amt [amount] Given...1...Date...4/4 [4/4/16]...Time...9A [9:00 a.m.]...Amt [amount] Given...1...Date...4/5 [4/5/16]...Time...9A [9:00 a.m.]...Amt [amount] Given...1..." The narcotic count sheet indicated Resident #D received 1 mg of Clonazepam, at 9:00 a.m., on 3/3/16, 4/4/16 and 4/5/16 but should have received 2 mg per the physician order on 12/13/14.</p> <p>The narcotic count sheet, dated 2/27/16, included, but was not limited to, the following: "...[Resident #D]...Clonazepam 2 mg tablet...Give 1 tablet via g-tube 2 times a day for seizures...Date...3/17/16...Time...12 noon...Amt [amount] Given...1...Date...3/30</p>			

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	<p>[3/30/16]...Time...12p [12:00 p.m.]...Amt [amount] Given...1...Date...3/31</p> <p>[3/31/16]...Time...1p [1:00 p.m.]...." The narcotic count sheet indicated Resident #D received 2 mg in the of Clonazepam on 3/17/16, 3/30/16 and 3/31/16 but should have received 1 mg per the physician order dated 12/13/14.</p> <p>The narcotic count sheet, dated 3/30/16, included, but was not limited to, the following: "...[Resident #D]...Clonazepam 2 mg tablet...Give 1 tablet via g-tube 2 times a day for seizures...Date...4/8 [4/8/16]...Time...12p [12:00 p.m.]...Amt [amount] Given...1...Date...4-30</p> <p>[4/30/16]...Time...1p [1:00 p.m.]...Amt [amount] Given...1...." The narcotic count sheet indicated Resident #D received 2 mg of Clonazepam on 4/8/16 and 4/30/16 but should have received 1 mg per the physician order dated 12/13/14.</p> <p>The narcotic count sheet, dated 4./30/16, included, but was not limited to, the following: "...[Resident #D]...Clonazepam 2 mg tablet...Give 1 tablet via g-tube 2 times a day for seizures...Date...5-1 [5/1/16]...Time...1p [1:00 p.m.]...Amt [amount] Given...1...." The narcotic count sheet indicated Resident #D received 2 mg of Clonazepam on 5/1/16 but should have</p>			

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	<p>received 1 mg per the physician order dated 12/13/14.</p> <p>The narcotic count sheet, dated 3/30/16, for Clonazepam 1 mg due at 12 noon indicated Resident #D did not receive the scheduled dose on 4/25/16.</p> <p>The narcotic count sheet, dated 3/30/16, for Vimpat 200 mg, 1 tablet per g-tube 2 times a day, indicated Resident #D did not receive the scheduled doses on 4/25/16 and 4/26/16, due at 9:00 a.m.</p> <p>During an interview on 5/24/16 at 12:45 p.m., the DON (Director of Nursing) indicated there were medication administration errors for Resident #D and an investigation was completed.</p> <p>The document titled, "Medication Errors Worksheet", dated 5/4/16 at 11:00 p.m., was provided by the DON on 5/24/16 at 2:00 p.m. It included, but was not limited to, the following: "...Name of Nurse: Multiple Nurses...Date of error: 4/7/16, 4/11/16, 4/18/16. 4/20/16...Brief description of error: Incorrect doing of Phenobarbital...Type of Error...Wrong dose...Anticonvulsants...Type of Variance...Omission...Wrong dose...Medication Errors Severity Rating...Category C - An error occurred that reached the resident but did not</p>			

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	<p>cause patient harm...Possible causes...Human factors...Possible contributing factors...Failure to check medications with MAR [Medication Administration Record]...Phase in the Medication Use Process...Administering: incorrect medication...."</p> <p>The document titled, "Medication Errors Worksheet", dated 5/4/16 at 11:00 a.m., was provided by the DON on 5/24/16 at 2:00 p.m. It included, but was not limited to, the following: "...Name of Nurse: Multiple Nurses...Date of error: 4/18/16, 4/25/16, 4/30/16, 5/1/16...Brief description of error: Clonazepam 2 mg given @ [at] noon instead of 1 mg tab...Type of error...Wrong dose...Barbituates...Type of Variance...Wrong dose...Medication Errors Severity Rating...Category C - An error occurred that reached the resident but did not cause harm...Possible causes...Name confusion...Possible contributing factors...Misread medications label...Phase in the Medications Use Process...Administering: incorrect medication...."</p> <p>The document titled, "Medication Errors Worksheet", dated 5/4/16 at 11:30 a.m., was provided by the DON on 5/24/16 at 2:00 p.m. It included, but was not limited</p>			

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	<p>to, the following: "...Name of Nurse: Multiple Nurses...Date of error: 4/25/16, 4/26/16...Brief description of error: Missed doses of Vimpat...Type of error...Omission...Anticonvulsants...Type of Variance...Omission...Medication Errors Severity Rating...Category C - An error occurred that reached the resident but did not cause harm...Possible causes...Human factors...Possible contributing factors...Failure to follow policy/procedure...Phase in the Medications Use Process...Administering: incorrect medication...."</p> <p>During an interview on 5/24/16 at 4:00 p.m., the DON indicated she had spoken with the nurses, individually, regarding the medication errors. The DON also indicated there was no inservice completed for all nursing staff related to the medication errors.</p> <p>On 5/24/16 at 5:00 p.m., the Administrator provided a copy of the document titled, "[name of pharmacy] LTC FACILITY PHARMACY SERVICES AND PROCEDURES MANUAL". It included, but was not limited to, the following: "...Policy #/Title...Medication-Related Errors...Procedure...4. Administration Errors: In the event of an administration</p>			

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	<p>error, Facility staff should follow Facility policy relating to medication administration errors. Examples of administration errors include, but are not limited to...Dose error: Facility administers to the resident a medication dose that is greater than or less than the amount ordered by Physician...Omission error: Facility fails to administer an ordered dose to the resident...."</p> <p>During an interview on 5/24/16 at 5:20 p.m., the DON indicated there was no policy in place regarding what to do if there is a medication error.</p> <p>This Federal tag relates to Complaint IN00199101</p> <p>3.1-48(c)(2)</p>			