| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155100 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING | (X3) DATE SURVEY COMPLETED 10/17/2011 |
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| NAME OF PROVIDER OR SUPPLIER GARDEN VILLA | | STREET ADDRESS, CITY, STATE, ZIP CODE 2111 NORTON LN BEDFORD, IN47421 | |

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| F0000 | This visit was for the Investigation of Complaint IN00097496.<br><br>Complaint IN00097496- Substantiated, federal/state deficiencies related to the allegation are cited at F333.<br><br>Survey date: October 17, 2011.<br><br>Facility number: 000040<br>Provider number: 155100<br>AIM number: 100274460<br><br>Survey team:<br>Melinda Lewis, RN, TC<br><br>Census bed type:<br>SNF 14<br>SNF/NF 140<br>Total 154<br><br>Census payor type<br>Medicare 14<br>Medicaid 127<br>Other 13<br>Total 154<br><br>Sample: 3<br><br>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2. | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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| | Quality review completed on October 18, 2011 by Bev Faulkner, RN | | | |
| F0333 SS=D | The facility must ensure that residents are free of any significant medication errors.<br><br>Based on interview and record review, the facility failed to ensure the correct dose of Keppra (antiseizure medication) resulting in Resident B receiving 15,000 mg instead of 1,500 mg for two doses for 1 of 3 residents reviewed with liquid medications. Resident B<br><br>Findings include<br><br>The clinical record for Resident B was reviewed on 10/17/11 at 8:30 A.M. The record indicated Resident B had a diagnosis of anoxic brain injury. The MDS [Minimum Data Set] assessment, dated 10/5/11, indicated Resident B was in a persistent vegetative state and was dependent on staff for care. | F0333 | What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident B's keppra was placed on hold and a level was obtined. The M.D. was notified and orders were received.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?All residents have the potential to be affected by the alleged deficient practice. All admissions for the past 30 days had their orders reviewed. No other residents were found to be affected. All residents who were on keppra also had their orders reviewed for the appropriate dose. No residents were found to be affected.What measures will be put into place or what systemic changes will be made to ensure | 10/28/2011 |

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| | The Admission orders, dated 9/21/11, indicated an order for "Keppra (antiseizure medication) 1500 mg = 115 ml per peg tube q [every] 12 hours."<br><br>The Nurses Notes, dated 9/21/11 at 4:10 P.M., indicated "...admitted to room (number). Transferred to this facility from (hospital name) per ambulance via stretcher...Nursing Admission Assessment Record completed....Resident unresponsive. Eyes opened at times..." The note lacked documentation the physician had been notified of the admission and approved the admission orders.<br><br>In an interview with LPN # 1 on 10/17/11 at 9:00 A.M., she indicated she had assisted with the admission of Resident B. She stated that she and the Unit Manager had questioned the dose of the Keppra and contacted the pharmacist. LPN # 1 indicated the pharmacist stated the dose should not be 115 ml but 150 ml. LPN # 1 indicated the Nurse Practitioner was then contacted and gave a clarification order based on the pharmacist recommendation to give Keppra 150 ml every 12 hours. LPN # 1 stated she did not look the medication up in the drug book but from experience felt it was a high dose. | | that deficient practice does not recur?Nursing staff were inserviced on October 21, 2011. Admission orders are now reviewed by 2 licensed nurses. How the corrective actions will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place?The corrective action will be monitored by the Director of Nursing Services or her designee three times weekly for 1 month and results reported to QA & A. If 100 % compliant the orders will be reviewed weekly. If not 100% compliant the nurse will receive immediate education and the audits increased as needed.By what date the systemic changes will be completed.October 28, 2011 | |

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| | The Nurses Notes, dated 9/21/11 at 6:30 P.M., indicated "Received new orders from (name) Nurse Practitioner for ...clarification order for Kepra (sic) 1500 mg = 150 ml per peg tube q [every] 12 hrs [hours]..."<br><br>The Nursing 2012 Drug Handbook, located on the unit where Resident B resided was reviewed on 10/17/11 at 9:40 A.M. The book indicated "...Keppra...Oral solution: 100 mg/ml...Adults and adolescents age 16 or older: Initially, 500 mg P.O. b.i.d. [by mouth two times daily]. Increase by 100mg/day every 2 weeks to daily dose of 3000 mg..."<br><br>The September 2011 Medication Administration Record indicated Resident B had received 150 ml Keppra (15,000 mg) on the evening of 9/21/11 and the morning of 9/22/11.<br><br>A Physician order, dated 9/22/11 at 6:00 P.M., indicated "1. D/C [discontinue] current Keppra order. 2. Start 15 ml Keppra 3. Draw Keppra level stat. 4. Hold Keppra until lab results are back."<br><br>The Serum Levetiracetam (generic name of Keppra) level drawn on 9/22/11 at 1800 (6:00 P.M.) indicated 175.0 mcg/ml. Therapeutic Levels: Drug Dosage 500 mg | | | |

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| | BID- Trough 3.1-10.0 mcg/ml. Peak 10.0-25.0 mcg/ml. Drug Dosage 1000 mg BID- Trough 4.9-37.1 mcg/ml. Peak 30.0-40.0 mcg/ml. Drug Dosage 1500 mg BID- Trough 7.0-34.0 mcg/ml. Peak 36.1-70.0 mcg/ml..."<br><br>The facility policy and procedure for Administering Medications, dated 3/04, was provided by the Director of Nursing on 10/17/11 at 8:45 A.M. The policy indicated "...Should a dosage seem excessive considering the resident's age and medical condition or a medication order seems to be unrelated to the resident's current diagnosis or medical condition, the person preparing/administering the medication shall contact the resident's attending physician or the facility's medical director for further instructions...The individual administering the medication must ensure that the right medication, right dosage, right time and right method of administration are verified before the medication is administered..."<br><br>In an interview with the Pharmacist, on 10/17/11 at 10:15 A.M., he indicated the pharmacy had a back up system in place to catch errors. He further indicated it had worked as another Pharmacist had caught the error on 9/22/11. | | | |

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| | An investigation summary, no date, was provided by the Director of Nursing on 10/17/11 at 9:30 A.M. The summary indicated "...Upon admission on 9/21/11 hospital admission orders were faxed to (name) pharmacy. (Name) Pharmacist, (name) contacted Garden Villa for a clarification order for Keppra. The clarification order was for the patient to receive Keppra 150ml/1500 mg po bid. The nurse wrote down how the order needed to read and read back to pharmacist for verification. The order was then approved by Nurse Practitioner. The patient received an 8 p dose on 9/21 and an 8 a dose on 9/22. On 9/22 a call was received from (name) pharmacist (name) stating that the clarification order was incorrect. The Nurse Practitioner was notified, the Keppra was placed on hold and Keppra levels were drawn."<br><br>The Director of Nursing also provided two medication error reports one for each nurse who had given the Keppra to Resident B. Both reports indicated the corrective action taken was Keppra placed on hold. Keppra levels drawn. Poison control contacted per (name) NP [Nurse Practitioner].<br><br>3.1-48(c)(2) | | | |

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