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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 04/24/2014 |
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| NAME OF PROVIDER OR SUPPLIER SANDERS GLEN | STREET ADDRESS, CITY, STATE, ZIP CODE 334 S CHERRY ST WESTFIELD, IN 46074 |
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| R000000 | <p>This visit was for the Investigation of Complaints IN00144538 and IN00148030.</p> <p>Complaint IN00144538 Substantiated. State deficiencies related to the allegation is cited at R0052.</p> <p>Complaint IN00148030 Substantiated. State deficiencies related to the allegations are cited at R0036, R0241, and R407</p> <p>Unrelated State findings cited.</p> <p>Survey Dates: April 23 & 24, 2014</p> <p>Facility number: 005657 Provider number: NA AIM number: NA</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: Residential: 109 Total: 109</p> <p>Census payor type:Other: 109 Total: 109</p> <p>Sample: 6</p> <p>These State findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality Review was completed by Tammy Alley RN on April 28, 2014. 410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency</p> | R000000 | | |
| R000036 | | | | |

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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| | <p>(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:</p> <p>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or</p> <p>(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.</p> <p>Based on record review and interview the facility failed to ensure a resident's physician was immediately notified, in that when a resident did not receive the prescribed medication as ordered, the nursing staff failed to immediately notify the physician for possible intervention for 1 of 3 residents reviewed in a sample of 6 for possible medication errors. (Resident "B").</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 04-23-14 at 11:00 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, a right above the knee amputation and anemia. These diagnoses remained current at the time of the record review.</p> <p>The resident was assessed with an upper respiratory infection and the nursing staff received physician orders, dated 03-19-14 for "Medrol Dose pack [a steroidal medication] - use as directed and Z-pack [an antibiotic] - use as directed."</p> <p>The pharmacy delivery document indicated the medication arrived at the facility on</p> | R000036 | <p>This facility immediately provides necessary medical intervention upon any significant decline in a resident's status.</p> <p><u>Corrective action for identified resident(S):</u></p> <p>Resident B has since discharged from facility.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>The Director of Nursing or designee reviewed all resident records to ensure physician notification was made regarding any significant decline in a resident's physical, mental or psychosocial status. Appropriately prescribed treatments, if ordered, were administered. No other residents were identified to have a significant decline in physical, mental or psychosocial status.</p> <p><u>Measures to prevent recurrence:</u></p> | 05/09/2014 | | | |

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| | <p>03-20-14 at 16:33 [4:33 p.m.], with 21 tablets in the Medrol packet and 6 tablets in the Z-pack packet.</p> <p>The instruction on the Medrol packet instructed the nursing staff as follows: "1st day - take 2 tablets before breakfast, 1 tablet after lunch and supper and 2 tablets at bedtime." "2nd day - take 1 tablet before breakfast, 1 tablet after lunch and supper, and 2 tablets at bedtime." "3rd day - take 1 tablet before breakfast, and 1 tablet after lunch, supper and at bedtime." "4th day - take 1 tablet before breakfast, after lunch and at bedtime." "5th day - take 1 tablet before breakfast and at bedtime." "6th day - take 1 tablet before breakfast. Unit of use 21 tablets."</p> <p>The instruction on the Z-pack instructed the nursing staff to administer 2 tablets for the first dose and 1 tablet daily for four days."</p> <p>During an interview on 04-23-14 at 9:30 a.m., licensed nurse #1 indicated "I was going off my shift and [name of resident] had been sick and the doctor had ordered the Z-pack and the Medrol. The evening nurse gave [name of the resident] the whole packet of the Z-pack, and he had a change in condition and had to be sent out to the hospital. I told the evening shift nurse that we could start the Z-pack the next day, depending on when it was delivered. [Name of resident] got bad and was sent to the hospital the next day."</p> | | <p>The Director of Nursing or designee will review resident records for any significant resident change on an ongoing basis. All residents with significant decline in physical, mental or psychosocial status will have their physician and family notified of the change in status. Facility will comply with physician's recommended treatments, as ordered. All licensed nurses, including Employee #13 and Employee #14 have been in-serviced by the Director of Nursing regarding the necessity to contact the resident's physician with any significant decline in a resident's physical, mental or psychosocial status. (Attachment A)</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>Director of Nursing or designee will monitor, through the 24 Hour Report process, to ensure physician notification was made for changes in resident's status' on a daily basis. Director of Nursing or designee will ensure physician notification regarding any significant status changes in residents. Findings will be reported to the Quality Assurance Team for further action and recommendations as indicated.</p> | | | | |

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| | <p>A review of the Nurses Notes dated 03-22-14 at 1:00 a.m., indicated "Resident c/o [complained of] SOB [shortness of breath]. O2 [oxygen] saturation 87 % on RA [room air]. Resident wheezing et [and] having difficulty speaking. States 'I need oxygen.' Resident has no order for oxygen. 911 notified per resident request. Resident transported to [name of hospital] via ambulance."</p> <p>During a subsequent interview on 04-24-14 at 11:00 a.m., employee #17 indicated she was aware of a medication error for [name of resident]. "The nurse [#13] reversed the meds. [medications]. I know because the night shift nurse found the error and told me about it."</p> <p>During an interview on 04-24-14 at 10:00 a.m., the Director of Nurses indicated the medications came in on the day they were ordered and due to being late, they were administered the next day." The Director of Nurses indicated, "We think she [licensed nurse #13] gave the Z-pack instead of the Medrol."</p> <p>A review of the Medication Administration record for March 2014 indicated the resident was to receive the Medrol medications as directed on the instruction sheet, as well as the Z-pack. The Medication Administration record clearly instructed the nurse to administer 2 tablets at 9:00 p.m., and on the next line instructed the nurse to administer 1 tablet daily for four days at 9:00 p.m..</p> <p>The Medrol doses for 8:00 a.m. (2 tablets) were signed off as administered, 12:00 p.m. (1 tablet) was signed off as administered on</p> | | | |

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| | <p>03-21-14, and 2 tablets of the Z-pack were documented as given on 03-20-14 at 9:00 p.m., and 1 tablet administered on 03-21-14 at 9:00 p.m.</p> <p>During interview on 04-24-14 at 10:00 a.m., the Director of Nurses indicated she concluded through her investigation the Medrol tablets scheduled to be administered on 03-21-14 at 8:00 a.m. (2 tablets) and 12:00 p.m. (1 tablet) were not given "because when the evening shift nurse started to provide medications, she found that the Medrol packet had not yet been started. We think [licensed nurse #13] gave 3 tablets of the antibiotic to [name of resident]."</p> <p>A review of the facility "Medication Error Report," dated 03-21-14 indicated the following:"Date of error - 03-24-14 at 8:00 a.m. Date of report 03-22-14. [Name of Nurse Practitioner] notified on 03-22-14 at 4:10 p.m."</p> <p>"Description of error - Nurse picked up and gave wrong drug package. Administered no Methylprednisone [Medrol] and instead gave 2 tabs [tablets] of Azithromycin 250 mg [milligram] tabs. Wrong medication - Misread order."</p> <p>A review of Licensed Nurse #13 employee file indicated "Verbal warning - date of violation 03-21-14 - Administered wrong medication. Picked up wrong package. To avoid further discipline employee should thoroughly review name on medication package and verify with medication MAR [Medication Administration Record] that correct dose, medication, and time are followed. Call prescriber to report error."</p> | | | |

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| R000052 | <p>A review of the employee file for Licensed Nurse #14, and identified by the Director of Nurses as the staff member who discovered the medication error, indicated the following: "Verbal Warning - date of violation 03-21-15 at 5:00 p.m., Discovered medication error. [Name of licensed nurse] realized a medication error potentially happened when she administered 5:00 p.m., Methylprednisone [Medrol] tablet and discovered no medications were missing from the package. To avoid further discipline the employee should immediately notify the DON [Director of Nurses] and the prescriber of the medication error. Always notify DON by phone rather than a note in the DON mailbox."</p> <p>A review of the facility policy on 04-24-14 at 10:00 a.m., titled "Resident Assessment," and dated 12-10-2007, indicated the following:</p> <p>"Policy: Assessments will be performed by the Director of Nursing and/or licensed nurse designee. Data obtained during assessment is used to determine that resident's needs for care, treatment, and/or develop a plan of care."</p> <p>"Procedure: Resident's physician will be immediately notified upon a significant decline in physical, mental or psychosocial conditions."</p> <p>This State finding relates to Complaint IN00148030. 410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse;</p> | | | |

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| | <p>(3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion.</p> <p>Based on record review and interview the facility failed to ensure a resident was not neglected in that when a resident needed assistance, the nursing staff failed to immediately aid the resident needs for 2 of 6 sampled residents. (Resident "D" and "F").</p> <p>Findings include:</p> <p>The record for Resident "D" included, but were not limited to arthritis, hypertension, depression, and a left shoulder replacement. These diagnoses remained current at the time of the record review.</p> <p>During an interview on 04-23-14 at 10:00 a.m., the resident indicated, "I had fallen and used the alarm and no one came to help me. I think it was about 20 minutes. I started screaming and the nurse said that is when she heard me and that her beeper did not go off. I would think they should check the beeper between shifts to make sure they work."</p> <p>A review of the nurses notes, dated 01-19-14 at 8:45 p.m. indicated "This writer heard someone calling for help and located resident in [room number] leaning on left side on side table - assisted resident into easy chair within three steps distance. Resident very upset that assistance wasn't more prompt. CNA [Certified Nurses Aide] also arrived to help after she completed showering another resident. This writer explained that she did not hear the pager but did hear someone asking for help. Resident still very upset</p> | R000052 | <p>This facility ensures all resident receive the care and services needed.</p> <p><u>Corrective action for identified resident(S):</u></p> <p>Identified residents D and F were re-interviewed on 5/5/2014, by the administrator to determine satisfaction with responses to their grievances and to ensure the staff have been responding in a timely manner. Both identified residents report satisfaction with the staffs response to the nurse call system.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>All residents were privately interviewed by the Administrator, or designee from the management team to determine if any residents had concerns with the staff responding in a timely manner to the nurse call system. (Attachment G) No residents reported dissatisfaction with the nurse call response time.</p> <p><u>Measures to prevent recurrence:</u></p> <p>The Director of Nursing in serviced all nursing staff,</p> | 05/09/2014 | | | |

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| | <p>refused offer of ice pack to left shoulder, hs [night time] meds. [medications] and vital signs. Resident threw alarm bracelet in trash where CNA retrieved it to put in DON mailbox."</p> <p>A review of the facility "Grievance Log," on 04-23-14 10:30 a.m. indicated two (Residents "D" and "F") residents complained about the lack of staff responding immediately to their Emergency Call System. Resident "F" indicated the "Resident report response to call light was too long."</p> <p>A review of the "Grievance/Concern Form," dated 03-06-14, on 04-24-14 at 10:30 a.m., indicated CNA #16 was counseled about the "necessity of answering call lights ASAP. If can't, contact nurse. Night nurse requested to monitor call lights."</p> <p>A "counseling" report dated 11-23-13 to CNA #16 and reviewed on 04-24-14 at 12:30 p.m. indicated the following:..."Please make sure you know how to properly use the pagers as well as how to change the batteries. These pagers can mean all the difference in a life or death situation when a resident needs help and the pagers are the resident's life line to our staff. I did have (2) residents concerned that their call lights were not answered during the early morning hours. The pagers have been working correctly all day today. It is imperative that you know how to go back and check the room numbers on your pager to see if you had any missed calls. It is the responsibility of all staff members to make sure their pagers are turned on and the battery is charged at the beginning of their shift. Please keep you pager turned on to both Tone and Vibrate. If you pager is making "buzzing" sound off and on that is</p> | | <p>including CNA #16, regarding nurse call system protocol, including education regarding the identified persons responsible for responding to the nurse call system. (Attachment A & B) Administrator and Director of Nursing, or designee will monitor the nurse call system, 7 days per week, during varied designated hours, for a period of one (1) month, by following up the "call" to ensure it was answered timely by nursing staff.</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>Designated facility staff will interview 15 different residents per month, for a period of 3months as a Quality Measure, to ensure resident satisfaction with timely response to the nurse call system. Findings will be reported to the Quality Assurance Team for further action and recommendation as indicated.</p> | | | | |

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| | <p>the indicator that the battery is low and will need changed. Please also make use of the enunciator panel in the business office as well as on the 2nd floor of Phase 1." This "counseling" was signed by the Director of Nurses.</p> <p>A review of CNA #16 employee file indicated the employee received a "Verbal Warning" on 11-25-13. The Warning/Notice indicated "(2) resident complaints of call lights not being answered." The "warning" indicated the employee response as "Staff member stated that the pagers have been acting up through the night, sometimes it will buzz and show room number and other times it doesn't. [Name of CNA #16] admitted to DON [Director of Nurses] that 'she doesn't know how to use the pagers or how to change the batteries.'"</p> <p>During an interview on 04-24-14 at 10:00 a.m., the Administrator indicated there are three staff members in the facility at night - one nurse, one CNA and a housekeeper. The Administrator further indicate the CNA is the "first responder" and if the CNA is unable to respond she is to contact the nurse.</p> <p>The job description for the Certified Nursing Assistant, reviewed on 04-24-14 at 12:30 p.m., indicated "Essential Duties and Responsibilities. 2. Provides for the residents' health needs, including but not limited to: responding to any call light or emergency alarm timely [bold type]."</p> <p>A review of the "duties binder" on 04-24-14 at 1:00 p.m., with information for all staff members included the following:"Engenius Phones/Pagers: Upon arrival for your shift always check to see that the battery is</p> | | | |

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| R000089 | <p>charged and the phone/pager is turned on. It is your responsibility to know how to use the phones, esp [especially] how to transfer a call. Aides please keep your phones in the bathroom when you are giving showers. If you can't hear your phone or pager while showering, please check each of them immediately after finishing the shower [bold type]. The Aides need to be the first responders on he portable incoming phone calls. Nurses are often in the middle of med. [medication] pass and are not able to respond to a call immediately. All calls are to be answered in a timely matter."</p> <p>This State finding relates to Complaint IN00144538. 410 IAC 16.2-5-1.3(e)(1-2)(f) Administration and Management - Noncompliance (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf.</p> <p>Based on record review and interview the facility failed to have a specific person designated to act in the absence of the administrator. This deficit practice had the potential to affect 109 of 109 residents residing in the facility.</p> <p>Findings included: During the entrance conference on 04-23-14</p> | R000089 | <p>This facility employ's a licensed administrator and maintains a reporting chain of command in the administrator's absence.</p> <p><u>Corrective action for identified resident(S):</u> No individual residents specifically identified and no</p> | 05/09/2014 |

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| R000241 | <p>at 9:00 a.m., the Director of Marketing indicated the Administrator and the Director of Nurses were out of town attending a conference. The Director of Marketing further indicated that she or any department head could act in the absence of the Administrator, however did not have written documentation to verify her ability to act in this position.</p> <p>On 04-23-14 at 11:20 a.m., the Director of Marketing indicated she spoke with the Administrator and "she instructed me to give you a copy of the Organization Chart and that she would draft an e-mail stating I was the person in charge in her absence."</p> <p>On 04-23-14 at 11:24 a.m., the Director of Marketing provided the facility "Organizational Chart," and an e-mail message from the Administrator which indicated, "Please consider this email authorization to discuss resident and state findings/information with [name of the Director of Marketing] during my absence from Sanders Glen. Please refer to the organizational chart for further direct report information."</p> <p>During interview on 04-24-14 at 10:30 a.m., the Administrator verified she did not have documentation in place to identify a person to act in her behalf during her absence from the facility.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and</p> | | <p>residents were affected.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>All residents have the potential to be affected.</p> <p><u>Measures to prevent recurrence:</u></p> <p>A signed organizational chart, along with a document authorizing management individuals to act on the behalf of the administrator have been placed in the facility's policy manual along with providing copies to the entrusted individuals. (Attachment C)</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>Administrator will maintain a signed document as part of a permanent record within the facility's policy manual. The Administrator will revise such document, upon any changes made to the designated individuals authorized to act on the administrators behalf. Documentation will be provided to the Quality Assurance Team as a matter of record.</p> | | | | |

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| | <p>the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides.</p> <p>Based on record review and interview the facility failed to ensure resident's received the prescribed medications as ordered by the physician, in that when residents had specific orders for medications, the nursing staff failed to ensure the resident received the medication as ordered for 3 of 4 residents reviewed for medication administration in a sample of 6. (Residents "B", "C", and "E").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 04-23-14 at 11:00 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, a right above the knee amputation and anemia. These diagnoses remained current at the time of the record review.</p> <p>The resident was assessed with an upper respiratory infection and the nursing staff received physician orders, dated 03-19-14 for "Medrol Dose pack [a steroidal medication] - use as directed and Z-pack [an antibiotic] - use as directed."</p> <p>The pharmacy delivery document indicated the medication arrived at the facility on 03-20-14 at 16:33 [4:33 p.m.], with 21 tablets in the Medrol packet and 6 tablets in the Z-pack packet.</p> | R000241 | <p>This facility provides the medications and residential nursing care as ordered by the resident's physician.</p> <p><u>Corrective action for identified resident(S):</u></p> <p>Identified resident's records were reviewed to determine any immediate action necessary. No immediate medical interventions were determined at this time. Resident's B and E have discharged from the facility. Resident C's treatment regime has concluded.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>Director of Nursing or designee reviewed all residents records and Medication Administration Records (MARS) for the past 30 days, to determine the need for any immediate interventions at this time. No additional interventions were indicated as needed at this time.</p> <p><u>Measures to prevent recurrence:</u></p> | 05/09/2014 | | | |

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| | <p>The instruction on the Medrol packet instructed the nursing staff as follows: "1st day - take 2 tablets before breakfast, 1 tablet after lunch and supper and 2 tablets at bedtime." "2nd day - take 1 tablet before breakfast, 1 tablet after lunch and supper, and 2 tablets at bedtime." "3rd day - take 1 tablet before breakfast, and 1 tablet after lunch, supper and at bedtime." "4th day - take 1 tablet before breakfast, after lunch and at bedtime." "5th day - take 1 tablet before breakfast and at bedtime." "6th day - take 1 tablet before breakfast. Unit of use 21 tablets."</p> <p>The instruction on the Z-pack instructed the nursing staff to administer 2 tablets for the first dose and 1 tablet daily for four days."</p> <p>During an interview on 04-23-14 at 9:30 a.m., licensed nurse #1 indicated "I was going off my shift and [name of resident] had been sick and the doctor had ordered the Z-pack and the Medrol. The evening nurse gave [name of the resident] the whole packet of the Z-pack, and he had a change in condition and had to be sent out to the hospital. I told the evening shift nurse that we could start the Z-pack the next day, depending on when it was delivered. [Name of resident] got bad and was sent to the hospital the next day."</p> <p>A review of the Nurses Notes dated 03-22-14 at 1:00 a.m., indicated "Resident c/o [complained of] SOB [shortness of breath]."</p> | | <p>The Director of Nursing in-serviced all nursing personnel regarding the administration of prescribed medications and/or treatments. (Attachment A) Employee #13, specifically, was observed by the Director of Nursing or designee, during a med pass administration as outlined in facility's Quality Assurance Program. (Attachment D) All licensed nursing staff were observed by the Director of Nursing or designee, during a med pass to ensure medication administration is demonstrated, as a Quality Measure. (Attachment E)</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>Resident MARs and physician's orders will be reviewed on a daily basis for 7 days, weekly for 4 weeks, then bi-weekly for 4 weeks to ensure proper medication administration. The Director of Nursing or designee will review MARs and ensure all necessary notifications are communicated to the physicians upon any known discrepancy. Unit manager or designee, will immediately report any medication error to the Director of Nursing. Medication Administration monitoring results will be forwarded to the Quality Assurance Team for review and further recommendations as indicated.</p> | | | | |

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| | <p>O2 [oxygen] saturation 87 % on RA [room air]. Resident wheezing et [and] having difficulty speaking. States 'I need oxygen.' Resident has no order for oxygen. 911 notified per resident request. Resident transported to [name of hospital] via ambulance."</p> <p>During a subsequent interview on 04-24-14 at 11:00 a.m., employee #17 indicated she was aware of a medication error for [name of resident]. "The nurse [#13] reversed the meds. [medications]. I know because the night shift nurse found the error and told me about it."</p> <p>During an interview on 04-24-14 at 10:00 a.m., the Director of Nurses indicated the medications came in on the day they were ordered and due to being late, they were administered the next day." The Director of Nurses indicated, "We think she [licensed nurse #13] gave the Z-pack instead of the Medrol."</p> <p>A review of the Medication Administration record for March 2014 indicated the resident was to receive the Medrol medications as directed on the instruction sheet, as well as the Z-pack. The Medication Administration record clearly instructed the nurse to administer 2 tablets at 9:00 p.m., and on the next line instructed the nurse to administer 1 tablet daily for four days at 9:00 p.m.</p> <p>The Medrol doses for 8:00 a.m. (2 tablets) were signed off as administered, 12:00 p.m. (1 tablet) was signed off as administered on 03-21-14, and 2 tablets of the Z-pack were documented as given on 03-20-14 at 9:00 p.m., and 1 tablet administered on 03-21-14 at 9:00 p.m.</p> | | | |

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| | <p>However, a review of the "Returned Medications" report indicated 18 of the 21 doses of the Medrol packet and 1 of the 6 Z-pack tablets were returned to the pharmacy.</p> <p>During interview on 04-24-14 at 10:00 a.m., the Director of Nurses indicated she concluded through her investigation the Medrol tablets scheduled to be administered on 03-21-14 at 8:00 a.m. (2 tablets) and 12:00 p.m. (1 tablet) were not given "because when the evening shift nurse started to provide medications, she found that the Medrol packet had not yet been started. We think [licensed nurse #13] gave 3 tablets of the antibiotic to [name of resident]."</p> <p>A review of the facility "Medication Error Report," dated 03-21-14 indicated the following:"Date of error - 03-24-14 at 8:00 a.m. Date of report 03-22-14. [Name of Nurse Practitioner] notified on 03-22-14 at 4:10 p.m."</p> <p>"Description of error - Nurse picked up and gave wrong drug package. Administered no Methylprednisolone [Medrol] and instead gave 2 tabs [tablets] of Azithromycin 250 mg [milligram] tabs. Wrong medication - Misread order."</p> <p>A review of Licensed Nurse #13 employee file indicated "Verbal warning - date of violation 03-21-14 - Administered wrong medication. Picked up wrong package. To avoid further discipline employee should thoroughly review name on medication package and verify with medication MAR [Medication Administration Record] that correct dose, medication, and time are</p> | | | |

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| | <p>followed. Call prescriber to report error."</p> <p>2. The record for Resident "C" was reviewed on 04-23-14 at 12:35 p.m. Diagnoses included, but were not limited to, cellulites, hypertension, short term memory loss, depression and anxiety. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had physician orders for "Cephalexin [an antibiotic] 500 mg one by mouth every 6 hours times 7 days. Finish all this medication unless otherwise directed by prescriber." This order was "faxed [facsimile]" to the pharmacy on 04-07-14.</p> <p>During an interview on 04-23-14 at 2:00 p.m., licensed nurse #10 indicated the medication was delivered to the facility on 04-07-2014.</p> <p>A review of the resident's Medication Administration Record for April 2014 instructed the nursing staff to provide the medication to the resident at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. Further review of the medication record indicated the medication was started on 04-08-14 at 12:00 a.m. The record further indicated the resident received the medication from 04-08-14 through 04-15-14 (eight days) with documentation the resident received 26 of the 28 doses, with a handwritten entry adjacent to the last dose administered on 04-15-14 at 6:00 a.m., noted as "completed." During an interview on 04-24-14 at 12:00 p.m., the Director of Nurses indicated the nursing staff probably realized the medication was not completed as directed in the 7 days and so the nurses continued to provide the medication to the resident.</p> | | | |

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| | <p>3. The record for Resident "E" was reviewed on 04-23-14 at 1:00 p.m. Diagnoses included, but were not limited to history of fractured hip, hypertension and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 02-13-14 for Cipro (an antibiotic) one by mouth two times a day for 10 days then one by mouth every day for preventative dose.</p> <p>A subsequent physician order dated 02-19-14 instructed the nursing staff to discontinue the previous antibiotic and to start Macrobid (an antibiotic) 100 mg by mouth two times a day for 10 days.</p> <p>A review of the February 2014 Medication Administration Record indicated the nursing staff started the Cipro antibiotic on 02-13-14 and continued to administer the medication through 8:00 p.m., on 02-19-14. A handwritten entry adjacent to this date indicated "dc'd [discontinued] 02-19-14."</p> <p>Further review of the February 2014 Medication Administration Record indicated the resident started to receive the subsequent antibiotic Macrobid on 02-20-14 at 8:00 p.m. and continued to receive the medication through 02-28-14 (9 days). A review of the March 2014 Medication Record indicated the resident received the medication from 03-01-14 through 03-07-14. Adjacent to the 03-07-14 dated a handwritten entry indicated "completed" for a total of 11 doses over 7 days.</p> <p>On 04-24-14 at 12:00 p.m., the Director of Nurses indicated she would call the</p> | | | |

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| | <p>pharmacy to see if an additional physician order had been obtained to continue the medication.</p> <p>On 04-24-14 at 2:00 p.m., the Director of Nurses indicated the resident only had the 1 order for the Macrobid medication. "It's called follow the leader."</p> <p>4. A review of the facility policy on 04-24-14 at 10:00 a.m., titled "Staff Administered Medication," and dated 03-01-2010 indicated the following:"Policy: The majority of medications administered in the community are in a pre-packaged dosage system. All medications to be given to one resident are individually packaged in a small sealed medication packet. The medications are administered by staff members as indicated by State regulations."</p> <p>"Procedure: 2. The Medication Sheets must be reviewed each time the medications are administered to make certain that changes have not been made of medications discontinued. 3. Remove the resident's medication container/package. All medication labels must include: resident's name, name of medication, dose directions, physician's name, and expiration date of medication, dispensing <sic> pharmacy name and prescription number. 4. Read the label on each bottle/packet. Read the label when removing the bottle/packet from the med. [medication] cart and compare it with resident's Medication Sheet. If there is a discrepancy in the directors <sic> between the label and an individual Medication Sheet verify against the physician order to make sure the Medication Sheet correctly reflects the physician order."</p> | | | |

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| R000349 | <p>This State finding relates to Complaint IN00148030.</p> <p>410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on record review the facility failed to ensure complete and accurate clinical records for 4 of 6 sampled residents. (Residents "B", "C", "E" and "A").</p> <p>Findings include:</p> <p>1. The record for Resident "B" was reviewed on 04-23-14 at 11:00 a.m. Diagnoses included, but were not limited to, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, a right above the knee amputation and anemia. These diagnoses remained current at the time of the record review.</p> <p>The resident was assessed with an upper respiratory infection and the nursing staff received physician orders, dated 03-19-14 for "Medrol Dose pack [a steroidal medication] - use as directed and Z-pack [an antibiotic] - use as directed.</p> <p>A review of the pharmacy delivery document indicated the medication arrived at the facility on 03-20-14 at 16:33 [4:33 p.m.], with 21 tablets in the Medrol packet and 6 tablets in</p> | R000349 | <p>This facility maintains complete and accurate resident records, which are readily accessible and systematically organized.</p> <p><u>Corrective action for identified resident(S):</u></p> <p>Identified resident's records were reviewed to determine any immediate action necessary. Resident's B and E have since discharged from the facility at time of review. Resident's A and C treatment regimes were concluded at time of review. Review of Resident's A and C records was conducted on 5/9/2014 and the documentation is complete.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>The Director of Nursing, Unit Manager or designee reviewed all</p> | 05/09/2014 |

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| | <p>the Z-pack packet.</p> <p>The instruction on the Medrol packet instructed the nursing staff as follows: "1st day - take 2 tablets before breakfast, 1 tablet after lunch and supper and 2 tablets at bedtime." "2nd day - take 1 tablet before breakfast, 1 tablet after lunch and supper, and 2 tablets at bedtime." "3rd day - take 1 tablet before breakfast, and 1 tablet after lunch, supper and at bedtime." "4th day - take 1 tablet before breakfast, after lunch and at bedtime." "5th day - take 1 tablet before breakfast and at bedtime." "6th day - take 1 tablet before breakfast. Unit of use 21 tablets."</p> <p>The instruction on the Z-pack instructed the nursing staff to administer 2 tablets for the first dose and 1 tablet daily for four days."</p> <p>A review of the Medication Administration record for March 2014 indicated the resident was to received the Medrol medications as directed on the instruction sheet, as well as the Z-pack. The Medication Administration record clearly instructed the nurse to administer 2 tablets at 9:00 p.m., and on the next line instructed the nurse to administer 1 tablet daily for four days.</p> <p>The Medrol doses for 8:00 a.m. (2 tablets) were signed off as administered, 12:00 p.m. (1 tablet) was signed off as administered on 03-21-14, and 2 tablets of the Z-pack were</p> | | <p>residents records and MARS for the past 30 days, to determine any immediate interventions at this time. No additional interventions were determined at this time.</p> <p><u>Measures to prevent recurrence:</u></p> <p>The Director of Nursing in-serviced all licensed nursing personnel regarding accuracy and completeness of MAR and resident record documentation per facility policy. (Attachment A) Employee #13 was observed by the Director of Nursing or designee during a med pass administration as outlined in facility's Quality Assurance Program. (Attachment D) All licensed nursing staff were observed by the Director of Nursing or designee, during a med pass to ensure proper medication administration is documented. (Attachment E)</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>The Director of Nursing or designee will monitor resident records for complete and accurate documentation on 5 residents per week for 12 weeks and present results to Quality Assurance Team for review and further recommendations based on results.</p> | |

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| | <p>documented as given on 03-20-14 at 9:00 p.m., and 1 tablet administered on 03-21-14 at 9:00 p.m.</p> <p>However, a review of the "Returned Medications" report indicated 18 of the 21 doses of the Medrol packet and 1 of the 6 Z-pack tablets were returned to the pharmacy.</p> <p>During interview on 04-24-14 at 10:00 a.m., the Director of Nurses indicated she concluded through her investigation the Medrol tablets scheduled to be administered on 03-21-14 at 8:00 a.m. (2 tablets) and 12:00 p.m. (1 tablet) were not given even though the nurse initialed the Medication Administration Record that she had administered the medication to the resident as ordered. The Director of Nurses further indicated she became aware of the error "because when the evening shift nurse started to provide medications, she found that the Medrol packet had not yet been started. We think [licensed nurse #13] gave 3 tablets of the antibiotics."</p> <p>2. The record for Resident "C" was reviewed on 04-23-14 at 12:35 p.m. Diagnoses included, but were not limited to, cellulites, hypertension, short term memory loss, depression and anxiety. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had physician orders for "Cephalexin [an antibiotic] 500 mg one by mouth every 6 hours times 7 days. Finish all this medication unless otherwise directed by prescriber." This order was "faxed [facsimile]" to the pharmacy on 04-07-14.</p> | | | |

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| NAME OF PROVIDER OR SUPPLIER SANDERS GLEN | STREET ADDRESS, CITY, STATE, ZIP CODE 334 S CHERRY ST WESTFIELD, IN 46074 |
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| | <p>A review of the resident's Medication Administration Record for April 2014 instructed the nursing staff to provide the medication to the resident at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. Further review of the medication record indicated the medication was started on 04-08-14 at 12:00 a.m. The record further indicated the resident received the medication from 04-08-14 through 04-15-14 (eight days) with documentation the resident received 26 of the 28 doses, with a handwritten entry adjacent to the last dose administered on 04-15-14 at 6:00 a.m. noted as "completed."</p> <p>The Medication Administration Record lacked documentation the medication had been provided on March 9, 2014 at 12:00 a.m., and 6:00 a.m., March 12, 2014 at 12:00 a.m., March 14, 2014 at 12:00 p.m., and March 15, 2013 at 12:00 p.m.</p> <p>3. The record for Resident "E" was reviewed on 04-23-14 at 1:00 p.m. Diagnoses included, but were not limited to history of fractured hip, hypertension and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order dated 02-13-14 for Cipro (an antibiotic) one by mouth two times a day for 10 days then one by mouth every day for preventative dose.</p> <p>A subsequent physician order dated 02-19-14 instructed the nursing staff to discontinue the previous antibiotic and to start Macrobid (an antibiotic) 100 mg by mouth two times a day for 10 days.</p> <p>A review of the February 2014 Medication</p> | | | |

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| | <p>Administration Record indicated the nursing staff started the Cipro antibiotic on 02-13-14 and continued to administer the medication through 8:00 p.m., on 02-19-14. A handwritten entry adjacent to this date indicated "dc'd [discontinued] 02-19-14."</p> <p>Further review of the February 2014 Medication Administration Record indicated the resident started to receive the subsequent antibiotic Macrobid on 02-20-14 at 8:00 p.m., and continued to receive the medication through 02-28-14 (9 days). A review of the March 2014 Medication Record indicated the resident received the medication from 03-01-14 through 03-07-14. Adjacent to the 03-07-14 dated a handwritten entry indicated "completed" for a total of 11 doses over 7 days.</p> <p>The nursing staff did not have a physician order to continue the medication and documented the medication as administered.</p> <p>4. The record for The record for Resident "A" was reviewed on 04-23-14 at 1:00 p.m. Diagnoses included , but were not limited to, diabetes, dementia and hypothyroidism. These diagnoses remained current at the time of the record review.</p> <p>The record indicated the resident had a "rash on neck and shoulders." The nursing staff received an order from the physician on 03-14-14 for 0.025 % Triamcinolone Acetonide Cream (an anti infective cream treatment) to be applied two times a day.</p> <p>During an interview on 04-23-14 at 9:15 a.m. licensed nurse #1 indicated she was aware of the resident identified with bed bugs, "once they brought in a machine. The heat from</p> | | | |

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| R000407 | <p>the machine was suppose to get rid of them. They didn't tell us anything."</p> <p>During an interview on 04-23-14, at 11:28 a.m., the Maintenance Director indicated the resident's family member "said they saw a bed bug so we got ahold of our exterminator and they came in and did a heat treatment to that room. I think the temperature was over 150 degrees."</p> <p>A review of the exterminator invoice dated 04-17-14 at 11:00 a.m., indicated the apartment was treated for bed bugs.</p> <p>The nurses notes lacked documentation of the improvement or decline in the treatment of the rash and also lacked documentation of the resident's family member expressing concern over bed bugs or the heat treatment provided by the exterminator.</p> <p>410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.</p> <p>Based on record review and interview the facility failed to have an infection control program in which the facility provided inservice education, in that when a resident was determined to have bed bugs, the facility</p> | R000407 | <p>This facility provides ongoing in-service education to facility staff.</p> <p><u>Corrective action for identified</u></p> | 05/09/2014 | | | |

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| | <p>administrative staff failed to provide the direct care givers, inservice education in the prevention and control of the bed bugs for 1 of 1 infection control programs reviewed and 1 of 1 resident identified with bed bugs in a sample of 6. (Resident "A").</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 04-23-14 at 1:00 p.m. Diagnoses included , but were not limited to, diabetes, dementia and hypothyroidism. These diagnoses remained current at the time of the record review.</p> <p>During an interview on 04-23-14 at 9:15 a.m. licensed nurse #1 indicated she was aware of the resident identified with bed bugs, "once they brought in a machine. The heat from the machine was suppose to get rid of them. They didn't tell us anything."</p> <p>During an interview on 04-23-14, at 11:28 a.m., the Maintenance Director indicated the resident's family member "said they saw a bed bug so we got ahold of our exterminator and they came in and did a heat treatment to that room. I think the temperature was over 150 degrees. The someone said the lady next door had a rash so we checked the room and I didn't see anything. I didn't know anything about bed bugs or what to look for so I "googled" it."</p> <p>A review of the exterminator invoice dated 04-17-14 at 11:00 a.m., indicated the apartment was treated for bed bugs. Recommendations included "remove clutter and/or debris."</p> <p>During subsequent interviews on 04-23-14</p> | | <p><u>resident(S):</u></p> <p>Resident A was reviewed/assessed with no findings.</p> <p><u>Identification and corrective action for other residents with the potential to be affected:</u></p> <p>All residents have the potential to be affected with no findings noted.</p> <p><u>Measures to prevent recurrence:</u></p> <p>All staff have been provided education regarding the specified pests and the protocol to follow upon identification of a suspected or confirmed case. Educational documentation will remain in each department and will remain accessible for future reference. All staff has reviewed educational documentation. (Attachment F) Management will maintain an open forum of communication and provide necessary education during facility's Employee Care Meetings.</p> <p><u>How will the facility monitor and who is responsible:</u></p> <p>The Administrator will include specified documentation in the monthly Quality Assurance records and report all future incidences to the Quality Assurance Team for monitoring. The Administrator will report any</p> | | | | |

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| | <p>the following staff members indicated the following:</p> <p>12:30 p.m. - Employee #9 "I didn't know anything about bed bugs until last week. I guess they wanted to keep it quiet."</p> <p>12:50 p.m. - Employee #8 "Yes [resident "A"] had a rash all over her body but we weren't sure if it wasn't a reaction to a medication. Then I heard she had bed bugs. They didn't tell us anything until we saw the big machine. Evidently they thought we didn't need to know."</p> <p>On 04-24-14 at 11:15 a.m. - Employee #17 indicated "I've helped [name of resident "A"] for a few months. I do it all because she can't do anything by herself. I found out about the bed bugs when I saw the machine in the hall. I went immediately and told everyone. I heard the DON [Director of Nurses] say 'I suppose everyone is flapping there jaws about it.'" The employee was unaware if a staff member had been identified with an unexplained rash. "I have a child who has a lot of sensitivities so I can't imagine bringing that home with me."</p> <p>A review of the documentation provided by the ISDH (Indiana State Department of Health)," titled "Prevention Control - Bed Bugs," was shared with the Administrator. Included in the document indicated "They [bed bugs] hide in dark places, easily spread from one location to another and can "hitch a ride" on clothing, backpacks, luggage and furniture."</p> <p>The Administrator provided the facility "Pest Control" policy and procedures on 04-24-14 at 10:00 a.m. The "Policy" indicated "Insects,</p> | | new suspected or confirmed cases to each Department Head for appropriate notification of each department's staff. | |

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| | <p>rodents and other pests will be controlled to minimize their presence on the premises."</p> <p>"Suggested Guidelines - 6. Pests identified in resident rooms and common areas will be referred to contractor for appropriate action. 7. Appropriate action will be taken to eliminate any reported pest situation in all departments and areas of the building."</p> <p>During interview on 04-24-14 at 2:10 p.m., the Administrator indicated the facility program is directed "mostly at the kitchen and we don't have a specific policy for bed bugs."</p> <p>This State finding relates to Complaint IN00148030.</p> | | | |