

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/14/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|---------|---|---------|--|--|
| F000000 | <p>This visit was for the Investigation of Complaints IN00143004 and IN00143601.</p> <p>Complaint IN00143004 unsubstantiated due to lack of evidence.</p> <p>Complaint IN00143601-Substantiated. Federal/State deficiency related to the allegations is cited at F333.</p> <p>Survey date: February 13 and 14 2014</p> <p>Facility number: 000273 Provider number: 15A011 AIM number: 100267870</p> <p>Survey team: Chuck Stevenson, RN, TC</p> <p>Census bed type: NF: 122 Total: 122</p> <p>Census payor type: Medicaid: 121 Other: 1 Total: 122</p> <p>Sample: 4</p> | F000000 | <p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Due to the low scope and severity of the survey finding, please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.</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.

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/14/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 |
|--------------------|--|---------------|--|----------------------|
| F000333 SS=D | <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on February 20, 2014, by Janelyn Kulik, RN.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview the facility failed to ensure a resident (Resident #C) was free of significant medication errors. The resident failed to receive 3 doses of a scheduled anti-seizure medication (Felbamate) and in a separate incident received 2 doses of another anti-seizure medication (Zonisemide) which were twice the ordered dosage for 1 of 3 residents reviewed for medications in a sample of 4.</p> <p>Findings include:</p> <p>The record of Resident #C was reviewed on 2/13/14 at 1:30 p.m. The resident's diagnoses included,</p> | F000333 | F333 Requires the facility to ensure a resident was free of significant medication errors. 1. Resident #C had his medication administration record, physician orders and labels on medications verified for accuracy per the MD order. An audit was also completed to ensure that all medications were present for administration per MD order. 2. All residents have the potential to be affected. All resident's medication administration record, physician orders and labels were verified for accuracy per the MD order. A complete audit of all residents medications were completed to ensure that all medications were present for administration per MD order. See corrective action below. 3. The medication administration policy | 02/15/2014 |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/14/2014 | |
| NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 | | | |
| | <p>but were not limited to, white matter disease of the brain, epilepsy, mental retardation, developmental delay, and delirium.</p> <p>A physician's order dated 10/30/12 indicated "May swipe VNS (Vagal Nerve Stimulator; an implanted device used in epilepsy patients who have frequent, intractable seizures) magnet for any seizure activity. Limit to 4 swipes in 24 hour period."</p> <p>During an interview on 2/13/14 at 11:00 a.m. the Director of Nursing indicated Resident #C had a rare inherited brain disease (white matter brain disease) that was progressive, incurable, and resulted in the resident having frequent seizures. He indicated the resident had been followed by a hospital based neurological service prior to admission to the facility and continued to be followed. He indicated the resident continued to have seizures on a frequent basis.</p> <p>A physician's order dated 9/24/12 indicated "Felbamate 600mg/5ml sus (600 milligrams in 5 milliliters suspension) Give 5 ml (600 milligrams) per G-tube (gastrostomy tube) every 6 hours DX: (diagnosis) Epilepsy."</p> | | <p>and procedure and med error policy and procedure were reviewed with no changes made. (See attachment A). The staff was inserviced on the above procedures. 4. All medication administration records and medication labels will be verified daily for accuracy as well as ensuring all medications are present for administration per MD order. The DON or his designee will utilize the nursing monitoring tool daily times four weeks, then weekly times four weeks, then every two weeks times two months then quarterly thereafter until 100% of compliance is obtained and maintained to ensure medications are being administered per policy. (See attachment B). The audits will be reviewed during the facility's quarterly quality assurance meeting and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before February 15, 2014.</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/14/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 |
|--------------------|---|---------------|---|----------------------|
| | <p>Medication Administration Records for November 2013 indicated Resident #C did not receive Felbamate on 11/03/13 at 8:00 p.m. and on 11/04/13 at 2:00 a.m. and 8:00 a.m. as ordered, as indicated by circling the medication administration time, per facility policy. The back of the medication administration record contained notes indicating "Felbamate ordered no supply" at 11/03/13 at 8:00 p.m. and 11/04/13 at 2:00 a.m. An un-timed note dated 11/04/13 indicated "Felbamate out- called pharmacy...insurance complications...approved today...del (delivery) due today."</p> <p>During an interview on 2/14/14 at 2:25 p.m. the Director of Nursing (D.O.N.) indicated L.P.N. #1 did not administer the Felbamate as ordered on 11/03/13 at 8:00 p.m. and again did not administer the medication on 11/04/13 at 2:00 a.m. as ordered. The D.O.N. also indicated L.P.N. #1 failed to follow facility policy and procedure by not ensuring the medication was re-ordered and available resulting in Resident #C not receiving the medication on 11/04/13 at 8:00 a.m. The D.O.N. also indicated the</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/14/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 |
|--------------------|---|---------------|---|----------------------|
| | <p>medication arrived from the pharmacy at 12:00 p.m. and was administered at the next scheduled time, 2:00 p.m. on 11/04/13.</p> <p>A physician's order dated 9/24/12 and indicated to be a current medication order on Resident #C's recapitulation of physician's orders for January 2014 indicated "Zonisemide susp (suspension) 10mg/ml (10 milligrams per milliliter) Give 30 ML (300 MG) per G-tube at bedtime DX: Epilepsy."</p> <p>An undated document titled "(Name of Resident ##C) Med Error Timeline" was received from the Administrator on 2/13/14 at 9:30 a.m., and represented to reflect incidents related to medication administration errors for Resident C on 1/23/14 and 1/24/14. It indicated Resident #C's primary pharmacy was unable to fill the order for Zonisemide, and it was obtained through an alternate pharmacy. The document noted a difference in the medication concentration as provided by the alternate pharmacy. The document indicated:</p> <p>"A possible medication error was reported on 1/27/14.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 02/14/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB | STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176 |
|--|--|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 |
|--------------------|--|---------------|---|----------------------|
| | <p>Order on the MAR (Medication Administration Record) and on physician orders: Zonisemide Susp. 10mg/ml Give 30ml (300 mg) per G-tube at bedtime.</p> <p>Order on the bottle received from (name of alternate pharmacy): Zonisemide 100/Ora-Blend Susp. Take 15ml (300 mg) per mouth at bedtime.</p> <p>A nurse (L.P.N. #2) gave 30ml of Zonisemide which was a double dose with the new bottle. He (Resident C) received the double dose on Thursday (1/23/14) and Friday (1/24/14)."</p> <p>A physician's progress note dated 1/29/14 at 1:15 p.m. indicated "I was informed of a med error...involving 2 doses of Zonegran (Zonisemide) (symbol for "at") 600mg daily instead of 300mg daily I saw him on 1/27/14 and he appeared well, with no adverse effects. His dose of Zonegran, although larger than usual, was within adult dosing range. The max recommended dose is 600 mg daily. I reviewed his labs and they were consistent with prior labs."</p> <p>During an interview on 2/14/14 at 2:25 the Director of Nursing (D.O.N.)</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 02/14/2014 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 | |
| | <p>indicated L.P.N. #2 failed to follow accepted nursing practice by not comparing the dosage and concentration on the medication package with the dosage and concentration of the physician's order, resulting in Resident #C receiving twice the intended dosage on 1/23/14 and 1/24/14. The D.O.N. indicated L.P.N. #2 had been counseled and reeducated concerning the medication error.</p> <p>A "Medication Administration Policy and Procedure" dated 9/05 received from the Assistant Director of Nursing on 2/13/14 at 10:15 a.m. and indicated to be a current facility policy indicated "Purpose: To administer medications according to the guidelines set forth by the State and Federal regulations...Procedure:...2. Medications will be checked 3 times to verify order with label during set up..."</p> <p>3.1-48 (c)(2)</p> | | | | |