

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155743	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/28/2015
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NAME OF PROVIDER OR SUPPLIER  GREEN-HILL MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 501 N LINCOLN AVE FOWLER, IN 47944
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F 000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00174260.</p> <p>Complaint IN00174260-Substantiated. Federal/State deficiency related to the allegation is cited at F333.</p> <p>Survey Dates: May 28, 2015</p> <p>Facility number: 000288 Provider number: 155743 AIM number: 100287380</p> <p>Census bed type: SNF/NF: 40 Total: 40</p> <p>Census Payor type: Medicare: 8 Medicaid: 26 Other: 6 Total: 40</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>The creation and submission of this plan of correction does not constitute an admission by this provider or any conclusion set forth in the statement of deficiencies or any violation of regulation. Provider desires that the 2567 plan of correction be considered the letter of credible compliance and requests a desk review certification in lieu of a revisit on or after 06-26-2015. James D. Sizemore, HFA Administrator</p>	
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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 333 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 record review and interview, the facility failed to ensure a resident was free from a significant medication error, related to not administering a chemotherapy medication (Alkeran) and a steroid medication (Prednisone) as ordered by the Oncologist, for 1 of 3 residents reviewed for medication in a total sample of 4. (Resident #B)</p> <p>Finding includes:</p> <p>Resident #B's record was reviewed on 05/28/15 at 9:45 a.m. The resident's diagnoses included, but were not limited to, multiple myeloma and diabetes mellitus.</p> <p>A Physician's Order, dated 02/26/15, indicated an order for Alkeran 2 mg (milligrams), give 9 tablets (18 mg) by mouth every day for 4 days every 6 weeks and Prednisone 20 mg, give 6 tablets (120 mg) every day for 4 days</p>	F 333	<p><b>F333 483.25(m) (2) RESIDENTS FREE OF MEDICATION ERRORS</b></p> <p>The facility must ensure that Residents are free of any significant medication errors. 1.) <i>What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice?</i></p> <p><b>1.) LPN# 1 was terminated and also reported to the Indiana Attorney General for further investigation.</b></p> <p><b>2.) Resident #B</b></p>	06/26/2015
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	<p>every 6 weeks.</p> <p>A Physician's Clarification Order, dated 04/10/15 at 3:50 p.m., written by LPN #1, indicated, "Per (Oncologist Name) office: (1) Prednisone 20 mg-take (6) tabs (tablets) (dose to =120 mg) po (by mouth) qd (every day) x 4 days following Velcade (Chemotherapy) injection-repeat q (every) 6 wks (weeks) (2) Melphalan (Alkeran) 2 mg-take (9) tabs (dose to =18 mg) po qd x 4 days following Velcade injection-repeat q 6 wks."</p> <p>Another Physician's Clarification Order, dated 04/10/15 at 4 p.m., written by LPN #1, indicated, "Per (Oncologist Name) office: (1) Prednisone 20 mg-give (6) tabs (dose to =120 mg) po qd x 4 days-repeat q 6 wks. (2) Melphalan 2 mg-give (9) tabs (dose to =18 mg) po qd x 4 days-repeat q 6 wks."</p> <p>A Nurses' Note, dated 04/11/15 at 9:30 a.m., indicated the Pharmacy had been notified the Melphalan 2 mg was not available in the facility and the Pharmacy indicated they were waiting for prior authorization and the medication would not be available until 04/15/15. The note indicated the resident's Physician was notified.</p> <p>A Nurses' Note, dated 04/11/15 indicated</p>		<p><b>continues to reside within the facility with no adverse reactions from the medication error</b></p> <p>2.) <i>How other Residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?</i></p> <p><b>1.) All Residents have the potential to be affected by the deficient practice</b></p> <p>2.) A facility wide audit was conducted on 05-22-2015 and found no further medication errors 3.) <i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.</i> 1.) All licensed nurses were re-educated on facility policies and procedures related to medication errors, medication administration, and physician telephone orders. Licensed nurses were re-educated on 05-28-2015 by the Director of Nursing and Corporate Nurse Consultant 2.) All telephone orders will be reviewed by the Director of Nursing or designee daily and cross referenced with the medication administration record</p>				

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	<p>this note was an addendum, but was timed at 9 a.m., indicated the Prednisone and Melphalan was rewritten on the MAR (Medication Administration Record) to start on the 15TH of April.</p> <p>The MAR, dated 04/15, indicated, "04/13/15-Prednisone 20 mg-give (6) tabs (dose to -120 mg) po qd x 4 days-repeat q 6 weeks." The MAR indicated the Prednisone was given on 04/13/15, 04/14/15, 04/15/15, and 04/16/15.</p> <p>The MAR, dated 04/15, indicated "04/13/15 Melphalan 2 mg-give (9) tabs (dose to = 18 mg) po qd x 4 d. repeat q 6 wks." The Mar indicated the resident received the Melphalan on 04/13/15 then there were initials with a circle around them (medication not given), no initials were documented for 04/15/15 and 04/16/15.</p> <p>A Physician's Order, dated 04/14/15 at 11 a.m., and written by LPN #1, indicated, "Per phone call c/ (with) (Oncology Care Name): (1) give Melphalan 2 mg (9) tabs po on 04-15-15, 04-16-15, 04-17-15 (2) give Prednisone 20 mg (6) tabs po on 04-14-15, 04-15-15, et 04-16-15."</p> <p>A Nurses' Note, dated 04/15/15 at 11:30 a.m., written by LPN #1, indicated, "Call placed to pharmacy @ 8:30 a (a.m.) et</p>		<p>to ensure telephone orders have been transcribed correctly 3.) Telephone orders found to have been written erroneously will be corrected immediately and the licensed nurse will be counseled immediately 4.) <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place and 1.)</b> The Director of Nursing or designee will review all telephone orders daily and cross reference the order with the medication administration record daily indefinitely. 2.) Director of Nursing or designee will submit findings of the daily audits to the Quality Assurance Committee monthly for review. Any errors identified will be corrected immediately and licensed nurses counseled as warranted. 3.) Consultant Pharmacist will submit to the Director of Nursing or designee a monthly report indicating any medication discrepancies found during their monthly consultation. 5.) <b>By what date the systemic changes will be completed</b> <b>June 26, 2015</b></p>	

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	<p>11:10 a re: Melphalan 0/ (not) delivered, memo sent to be delivered 4/16/15-call placed to (Oncology Care Name)...ok to give med (medication) starting 4/16/15 et also 4/17/15 &amp; 4/18/15 to complete..."</p> <p>The MAR, dated 04/15, indicated "04/15/15 Alkeran 2 mg-give (9) tab (dose to =18 mg) po qd (Melphalan) x 4 d. (repeat q 6 wks)." the MAR indicated the resident received the Melphalan on 04/16/15, 04/17/15, and 04/18/15 at 8 a.m.</p> <p>The MAR, dated 04/15, indicated the Prednisone dosage was given again on April 21, 22, 13, and 24, 2015. This was four days after the last dosage was given. (ordered to be repeated every six weeks).</p> <p>The MAR, dated 04/15, indicated the Alkeran dosage was given again on April 22, 23, 24, and 25, 2015. This was four days after the last dosage was given. (ordered to be repeated every six weeks).</p> <p>The MAR, dated 04/15, indicated the Prednisone dose was again given on 04/28/15, 04/29/15, and 04/30/15 (the last dose was scheduled for 05/01/15). This was three days after the last dose was given. (ordered to be repeated every six weeks).</p>			

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	<p>The MAR, dated 04/15, indicated the Alkeran dose was again given on 04/28/15, 04/29/15, and 04/30/15 (the last dose was scheduled for 05/01/15). This was two days after the last dose was given. (ordered to be repeated every six weeks).</p> <p>A Physician's Order, dated 04/30/15 at 2 p.m. and written by LPN #1, indicated, "Can repeat weekly Alkeran et Prednisone administration per (Oncology Care Name) scheduled injections."</p> <p>The MAR, dated 05/15, indicated the resident received the Prednisone and Alkeran doses on 05/01/15, then again on May 5, 6, 7, and 8, 2015, which was three days after the last dose. (ordered to be repeated every six weeks).</p> <p>There was no indication in the Nurses' Notes the Oncologist's Office was communicated with from 04/14/15 at 11 a.m. through 05/20/15 at 5 p.m., when orders were received for a stat complete blood count and comprehensive metabolic profile (electrolytes).</p> <p>An investigation of the increased dosages of Prednisone and Alkeran, dated 05/21/15, and received from the Administrator, indicated the Pharmacy had contacted the Oncologist's Office due</p>			

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	<p>to the amount of medication ordered from the facility for the resident. The investigation indicated additional doses of the Alkeran had been written on the MAR by LPN #1 and the medications were initialed as given. The resident had received 12 additional doses of Alkeran (and Prednisone). The investigation indicated there were no orders for the additional doses and it had just been transcribed on the MAR by LPN #1. The Oncology Nurse denied giving orders for the additional dosages. The Oncology Nurse indicated the Oncologist had not been in the office (04/30/15).</p> <p>A written statement, dated 05/21/15, and signed by LPN #1, indicated there had been "many phone calls" with the Oncologist's Office and the Pharmacy in regards to the Melphalan and the Prednisone. LPN #1 indicated the understanding was the medications were to be given when the resident received the Velcade injections. LPN #1 indicated she had written an order to give the medications weekly according to the Velcade injection schedule.</p> <p>During an interview on 05/28/15 at 11:39 a.m., the DoN (Director of Nursing) indicated the order on 04/30/15 was written by LPN #1 after the medication had been administered more than every</p>			

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	<p>six weeks. The DoN indicated if the order came from the Oncologist's Office, then the Oncologist was required to sign the Physician's Orders. The DoN indicated the Oncologist's Office had not given the orders to give the medications weekly and the order from the Oncologist's Office was every six weeks. The DoN indicated on approximately 04/27/15, the Pharmacy questioned the dosages. The DoN indicated after the Pharmacy had questioned the dosages, LPN #1 then wrote the order on 04/30/15 to repeat the dosages of the medication weekly.</p> <p>During an interview on 05/28/15 at 12:29 p.m., the Pharmacy Supervisor indicated the Pharmacist involved in the order was not available to interview at this time. She indicated the facility received the Alkeran and the Prednisone in the amount ordered for the four day dosage. The Pharmacist indicated the facility had requested more after the ordered amount had been delivered. The Pharmacist indicated they had spoke with LPN #1 each time they called the facility and LPN #1 clarified the orders each time and had faxed the order on 04/30/15 to the Pharmacy and due to the excessive amount requested, the Oncologist had been notified by the Pharmacist for a clarification of the order and this was</p>			
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	<p>when the error was found. The Pharmacist indicated she was unsure when the Oncologist had been notified.</p> <p>This Federal Tag relates to Complaint IN00174260.</p> <p>3.1-48(c)(2)</p>				