

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155630	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/09/2016
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NAME OF PROVIDER OR SUPPLIER  FLATROCK RIVER LODGE	STREET ADDRESS, CITY, STATE, ZIP CODE 904 E 11TH ST RUSHVILLE, IN 46173
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00200504.</p> <p>Complaint IN00200504 - Substantiated. Federal/state deficiencies related to the allegations are cited at F153, F282 and F425.</p> <p>Survey dates: August 8 and 9, 2016</p> <p>Facility number: 001126 Provider number: 155630 AIM number: 200011300</p> <p>Census bed type: SNF/NF: 49 Residential: 10 Total: 59</p> <p>Census payor type: Medicare: 8 Medicaid: 31 Other: 20 Total: 59</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of facts alleged or conclusions set forth in Statement of Deficiencies. The plan of Correction is prepared and executed solely because the provisions of federal and state law require it. The facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity to render adequate care.</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 0153 SS=D Bldg. 00	<p>Quality review completed by 30576 on August 18, 2016</p> <p>483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.</p> <p>Based on interview and record review, the facility failed to provide requested clinical records in a timely fashion for 1 of 3 residents reviewed for release of records in a sample of 3. (Resident #A)</p> <p>Findings include:</p> <p>In an interview with the Administrator on 8-9-16 at 3:25 p.m., she indicated the family of Resident #A verbally requested copies of the clinical record on 2-18-16. She indicated, "If I remember right, it was a verbal request for copies, not to view the records. I don ' t think we have</p>	F 0153	The facility does provide requested clinical records in a timely fashion. The records for this resident have already been provided to the family. An audit of clinical request for records was completed and there have been no other requests for anyone potentially affected. The facility will provide a copy of the medical record to the resident or legal representative upon written request and two (2) working days' advance notice to the facility. Written requests will be retained and logged in the HIPAA Disclosure Log. The nurses and management team will be in-serviced on this procedure by 9-8-16. The Administrator or designee shall monitor monthly for 6 months to ensure continued compliance. Any negative findings will be reported to QAPI who will determine the need for further monitoring.	09/08/2016

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	<p>a formal records request form. I'll have to see what we have as far as any kind of tracking for when records are requested and when we get them to the person or family."</p> <p>In an interview with the Administrator on 8-9-16 at 4:42 p.m., she indicated, "Normally, when we get records requests, we print the information immediately and then have other people [staff] go through it to make sure that we didn ' t forget anything. We make a copy of all the information that is copied for the patient and put it in a folder. I will have to see if I can find when the family either picked up the information or we let them know when they were ready for pick up." In interview with the Administrator on 8-9-16 at 5:22 p.m., she indicated, "I could not find anything in our records that said when the family was told the records were ready to be picked up or when they picked them up. I don ' t know that we have any tracking for records when somebody requests them. Knowing it takes a while to get the records copied and reviewed, I would say it was unlikely the family got the records within two days."</p> <p>On 8-9-16 at 5:35 p.m., the Administrator provided a portion of the "Resident Admission Agreement, " dated January,</p>			

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F 0282 SS=G Bldg. 00	<p>2004. This portion of the "Resident Admission Agreement" indicated, "The Resident of [sic] Legal Representative has the right upon oral or written request to access all records pertaining to himself/herself, including clinical records, within twenty-four (24) hours. After receipt of his/her records, the resident or Legal Representative has the right to purchase (at a cost not to exceed the community standard) photocopies of the records or any portions of them upon request and with two (2) days' advance notice to the Facility."</p> <p>This Federal tag relates to Complaint IN00200504.</p> <p>3.1-4(b)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure the physician orders for 1 of 3 residents reviewed for medication administration accuracy were properly followed which resulted in a</p>	F 0282	The facility does ensure the physician orders for medication administration accuracy are properly followed. Resident A's family and physician were notified on 1/23/16, and 1/27/16 of the medication error. Ongoing medication administration is monitored through the facility QAPI program and all errors are reviewed, investigated, and acted upon based on findings. All nurses will be in-serviced on proper medication passes by 9-8-16. Through QAPI the facility reviewed the EDK and has followed there	09/08/2016

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	<p>resident experiencing two medications errors, one of which resulted in the resident becoming very hypotensive (low blood pressure) resulting in the resident being sent to the local emergency room and subsequently hospitalized for three days related to the hypotension. Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 8-8-16 at 1:35 p.m. Her admission diagnoses on 1-19-16 included, but were not limited to, hypertension, urinary tract infection, shortness of breath and wheezing, agitation, anemia. An admission Social Services note, dated 1-19-16, indicated she was alert and oriented to person and place, but requiring looking at the clock for time. It indicated she was able to make her needs and wants known.</p> <p>In review of a faxed note to the attending physician from the facility, dated 1-22-16 at 12:55 p.m., it indicated the resident "c/o [complained of] R [right] knee pain, knee is swollen, red, warm to touch. [Sign for elevated] Temp 100.1 [degrees Fahrenheit]. Denies any specific injury. Res. [resident] can hardly bear any wt [weight] on R leg...Res states had polio as child and sometimes will have this</p>		<p>commendations of the medical director regarding medications and quantity to be included in the kit. The nurse responsible for the medication error involving resident A was terminated from her position on 1-27-16. The DON or designee will monitor three random medication passes per week for four weeks, then monthly for a total of six months to ensure continued compliance. Any negative findings will be reported to QAPI who will determine the need for further monitoring.</p>	

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	<p>pain in her knees. As far as redness and warmth, res denies any hx [history] of cellulitis. Res does have weakness and joint pain from osteoporosis but this is new onset according to res." The attending physician's faxed response, dated 1-22-16, indicated new orders for an xray of the right knee, colchicine 0.6 milligrams [mg] by mouth daily (medication used for gout) and to schedule an appointment with an area orthopedist.</p> <p>In an interview with the Administrator on 8-9-16 at 11:17 a.m., she indicated Resident #A, "had a new order for colchicine 0.6 mg for gout on 1-22-16. [The medication ] was entered to start on 1-23-16, but did not come in from pharmacy. Was not in EDK [Emergency Drug Kit]. One of the nurses looked in the EDK and pulled clonidine of 0.1 mg, 6 tabs, were pulled and given to the resident. Upon returning to the med room to document the med administration, she noticed she had pulled the wrong med. The doctor was immediately notified. He ordered to initially monitor BP hourly, then called back and changed it to every 15 minutes. Upon finding BP at 78, doctor was notified and he ordered to start an IV and to send out to the ER. The doctor requested the family contact information</p>			

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	<p>in order to contact them himself. She remained in the hospital and returned on 1-26-16 at her normal baseline."</p> <p>The Administrator indicated Resident #A had a second medication error, upon returning from the hospital. "Prior to going to the hospital, she had been on Zocor 40 mg. When she returned, the Zocor had been changed to 20 mg and she still had the 40 mg in her [medication] drawer. It was given in error. When the doctor was notified, he ended up changing the dose back to 40 mg."</p> <p>On 8-9-16 at 2:25 p.m., the Administrator provided a list of all medications in the facility's EDK. It indicated clonidine 0.1 mg, six tablets were available. It did not indicate colchicine was available in the EDK.</p> <p>In interview with the Administrator on 8-9-16 at 2:10 p.m., she indicated, "Right now, I can think of one resident that has a routine order for this medicine [clonidine] and a few others that may have it as a prn [as needed] order. But those residents would have it in the routine meds, not from the EDK. As far as I know, the EDK has not changed since the error."</p>			

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	<p>In review of the hospital discharge summary, dated 1-26-16, it indicated the admitting and discharge diagnosis was "hypotension." It indicated the "Hospital Course," included, but was not limited to, "[Name of Resident #A] was admitted to med/surg floor after getting 0.6 mg Clonidine PO [orally] by mistake of nurse at [name of facility] 18 hours prior to admission. She became hypotensive with systolics in the 70's. In the ER, she was given IV fluid bolus ultimately of 3 L [liters] in ER. BP [blood pressure] was started on dopamine drip [IV medication to enhance blood pressure]. She was weaned off Dopamine yesterday. This AM she is normotensive [blood pressure within normal range], but her BP is occasionally on the lower side. This morning she is feeling well and c/o only chronic right knee pain. I will discharge her again to [name of facility] today for continuing strengthening and rehab."</p> <p>The "Nursing 2014 Drug Handbook," it indicates clonidine is an antihypertensive medication in which an initial dosage is typically 0.1 mg twice daily and may be tapered up to 0.2 to 0.6 mg daily in divided doses. It indicates signs and symptoms of overdosage may include, but is not limited to, early hypertension followed by hypotension, low heart rate, respiratory and central nervous system</p>			

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	<p>depression, drowsiness and weakness, with elderly persons potentially more sensitive to the hypotensive effects of this medication.</p> <p>On 8-9-16 at 4:10 p.m., the Administrator provided a copy of a policy entitled, "Medication Administration-General Guidelines, " with an effective date of January, 2007. This policy indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication...Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label three times. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are administered in accordance with written orders of the attending physician..."</p> <p>On 8-9-16 at 4:10 p.m., the Administrator provided a copy of a policy entitled, "Medication/Treatment Error</p>			

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	<p>Administration Policy," with a revision date of July, 2015. This policy indicated, "This policy has been established to enable the facility to adopt a consistent approach in responding to medication and treatment administration errors. A facility medication/treatment error occurs when: a prescribed medication is not administered...the wrong medication is administered...failure to compare doctor's orders with pharmacy labels and medication administration record..."</p> <p>The "Nursing 2014 Drug Handbook," identifies "The eight 'rights' of medication administration," as the following:</p> <ol style="list-style-type: none"> <li>1. The right drug: Check the drug label and verify that the drug and form to be given is the drug that was prescribed.</li> <li>2. The right patient: Confirm the patient's identity by checking two patient identifiers.</li> <li>3. The right dose: Verify that the dose and form to be given is appropriate for the patient, and check the drug label with the prescriber's order.</li> <li>4. The right time: Ensure that the drug is administered at the correct time and frequency.</li> <li>5. The right route: Verify that the route by which the drug is to be given is specified by the prescriber and is appropriate for the patient...</li> </ol>			

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F 0425 SS=G Bldg. 00	<p>6. The right reason: Verify that the drug prescribed is appropriate to treat the patient's condition.</p> <p>7. The right response: Monitor the patient's response to the drug administered.</p> <p>8. The right documentation: Completely and accurately document in the patient's medical record the drug administered, the monitoring of the patient, including his response, and other nursing interventions."</p> <p>This Federal tag relates to Complaint IN00200504.</p> <p>3.1-35(g)(2)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each</p>			

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	<p>resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure the accuracy of medications administered to 1 of 3 residents reviewed for medication administration accuracy, which resulted in two medication errors. One of the errors resulted in the resident having very low blood pressure and requiring a three day hospitalization. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's clinical record was reviewed on 8-8-16 at 1:35 p.m. Her admission diagnoses on 1-19-16 included, but were not limited to, hypertension, urinary tract infection, shortness of breath and wheezing, agitation, anemia. An admission Social Services note, dated 1-19-16, indicated she was alert and oriented to person and place, but requiring looking at the clock for time. It indicated she was able to make her needs and wants known.</p> <p>In review of the hospital discharge summary, dated 1-26-16, it indicated the admitting and discharge diagnosis was "hypotension." It indicated the "Hospital</p>	F 0425	<p>The facility does ensure the physician orders for medication administration accuracy are properly followed. Resident A's family and physician were notified on 1/23/16, and 1/27/16 of the medication error. Ongoing medication administration is monitored through the facility QAPI program and all errors are reviewed, investigated, and acted upon based on findings. All nurses will be in-serviced on proper medication passes by 9-8-16. Through QAPI the facility reviewed the EDK and has followed there commendations of the medical director regarding medications and quantity to be included in the kit. The nurse responsible for the mediation error involving resident A was terminated from her position on 1-27-16. The DON or designee will monitor three random medication passes per week for four weeks, then monthly for a total of six months to ensure continued compliance. Any negative findings will be reported to QAPI who will determine the need for further monitoring.</p>	09/08/2016

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	<p>Course," included, but was not limited to, "[Name of Resident #A] was admitted to med/surg floor after getting 0.6 mg Clonidine PO [orally] by mistake of nurse at [name of facility] 18 hours prior to admission. She became hypotensive with systolics in the 70's. In the ER, she was given IV fluid bolus ultimately of 3 L [liters] in ER. BP [blood pressure] was started on dopamine drip [IV medication to enhance blood pressure]. She was weaned off Dopamine yesterday. This AM she is normotensive [blood pressure within normal range], but her BP is occasionally on the lower side. This morning she is feeling well and c/o only chronic right knee pain. I will discharge her again to [name of facility] today for continuing strengthening and rehab."</p> <p>In review of a faxed note to the attending physician from the facility, dated 1-22-16 at 12:55 p.m., it indicated the resident "c/o [complained of] R [right] knee pain, knee is swollen, red, warm to touch. [Sign for elevated] Temp 100.1 [degrees Fahrenheit]. Denies any specific injury. Res. [resident] can hardly bear any wt [weight] on R leg...Res states had polio as child and sometimes will have this pain in her knees. As far as redness and warmth, res denies any hx [history] of cellulitis. Res does have weakness and joint pain from osteoporosis but this is</p>			

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	<p>new onset according to res." The attending physician's faxed response, dated 1-22-16, indicated new orders for an xray of the right knee, colchicine 0.6 milligrams [mg] by mouth daily (medication used for gout) and to schedule an appointment with an area orthopedist.</p> <p>In an interview with the Administrator on 8-9-16 at 11:17 a.m., she indicated Resident #A, "had a new order for colchicine 0.6 mg for gout on 1-22-16. [The medication ] was entered to start on 1-23-16, but did not come in from pharmacy. Was not in EDK [Emergency Drug Kit]. One of the nurses looked in the EDK and pulled clonidine of 0.1 mg, 6 tabs, were pulled and given to the resident. Upon returning to the med room to document the med administration, she noticed she had pulled the wrong med. The doctor was immediately notified. He ordered to initially monitor BP hourly, then called back and changed it to every 15 minutes. Upon finding BP at 78, doctor was notified and he ordered to start an IV and to send out to the ER. The doctor requested the family contact information in order to contact them himself. She remained in the hospital and returned on 1-26-16 at her normal baseline."</p>			

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	<p>The Administrator indicated Resident #A had a second medication error, upon returning from the hospital. "Prior to going to the hospital, she had been on Zocor 40 mg. When she returned, the Zocor had been changed to 20 mg and she still had the 40 mg in her [medication] drawer. It was given in error. When the doctor was notified, he ended up changing the dose back to 40 mg."</p> <p>On 8-9-16 at 2:25 p.m., the Administrator provided a list of all medications in the facility's EDK. It indicated clonidine 0.1 mg, six tablets were available. It did not indicate colchicine was available in the EDK.</p> <p>In interview with the Administrator on 8-9-16 at 2:10 p.m., she indicated, "Right now, I can think of one resident that has a routine order for this medicine [clonidine] and a few others that may have it as a prn [as needed] order. But those residents would have it in the routine meds, not from the EDK. As far as I know, the EDK has not changed since the error."</p> <p>The "Nursing 2014 Drug Handbook," it indicates clonidine is an antihypertensive medication in which an initial dosage is typically 0.1 mg twice daily and may be</p>			

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	<p>tapered up to 0.2 to 0.6 mg daily in divided doses. It indicates signs and symptoms of overdosage may include, but is not limited to, early hypertension followed by hypotension, low heart rate, respiratory and central nervous system depression, drowsiness and weakness, with elderly persons potentially more sensitive to the hypotensive effects of this medication.</p> <p>On 8-9-16 at 4:10 p.m., the Administrator provided a copy of a policy entitled, "Medication Administration-General Guidelines," with an effective date of January, 2007. This policy indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication...Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label three times. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are</p>						

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	<p>administered in accordance with written orders of the attending physician..."</p> <p>On 8-9-16 at 4:10 p.m., the Administrator provided a copy of a policy entitled, "Medication/Treatment Error Administration Policy," with a revision date of July, 2015. This policy indicated, "This policy has been established to enable the facility to adopt a consistent approach in responding to medication and treatment administration errors. A facility medication/treatment error occurs when: a prescribed medication is not administered...the wrong medication is administered...failure to compare doctor's orders with pharmacy labels and medication administration record..."</p> <p>The "Nursing 2014 Drug Handbook," identifies "The eight 'rights' of medication administration," as the following:</p> <ol style="list-style-type: none"> <li>1. The right drug: Check the drug label and verify that the drug and form to be given is the drug that was prescribed.</li> <li>2. The right patient: Confirm the patient's identity by checking two patient identifiers.</li> <li>3. The right dose: Verify that the dose and form to be given is appropriate for the patient, and check the drug label with the prescriber's order.</li> <li>4. The right time: Ensure that the drug is</li> </ol>			

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R 0000  Bldg. 00	<p>administered at the correct time and frequency.</p> <p>5. The right route: Verify that the route by which the drug is to be given is specified by the prescriber and is appropriate for the patient...</p> <p>6. The right reason: Verify that the drug prescribed is appropriate to treat the patient's condition.</p> <p>7. The right response: Monitor the patient's response to the drug administered.</p> <p>8. The right documentation: Completely and accurately document in the patient's medical record the drug administered, the monitoring of the patient, including his response, and other nursing interventions."</p> <p>This Federal tag relates to Complaint IN00200504.</p> <p>3.1-25(b) 3.1-25(b)(2) 3.1-25(b)(9)</p> <p>This visit was for the Investigation of Complaint IN00200504.</p>	R 0000	Preparation and execution of this plan of correction does not constitute admission or agreement by this facility of the truth of facts alleged or conclusions set forth in Statement of Deficiencies. The plan of Correction is prepared and executed solely because the provisions of federal and state law require it. The	

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R 0241 Bldg. 00	<p>Complaint IN00200504 - Substantiated. Residential deficiencies related to the allegations are cited at R0241 and R0246.</p> <p>Survey dates: August 8 and 9, 2016</p> <p>Residential Census: 10</p> <p>Sample: 3</p> <p>These deficiencies are cited in accordance with 410 IAC 16.2-5.</p> <p>410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and 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 interview and record review, the facility failed to ensure medications were administered as ordered and incorrect medication dosages were not administered to 1 of 3 residents reviewed for accuracy of medication administration. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's clinical record was</p>	R 0241	<p>facility maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of residents nor are they of such character as to limit the facility's capacity to render adequate care.</p> <p>The facility does ensure medications are administered as ordered. Resident E's family and MD were notified 8/1/16 per the Physician notification policy. The facility is placing an alert sticker on all medications for residents with sound alike names. An audit was completed to identify any other residents with sound alike names to determine if stickers are needed. All nurses will be in-serviced by 9-8-16 on proper medication pass and the scope of practice for a QMA. The DON or designee will monitor three random medication passes per week for four weeks, then monthly for a total of six months to ensure continued compliance. Any negative findings will be reported to QAPI who will determine the need for further monitoring.</p>	09/08/2016

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	<p>reviewed on 8-9-16 at 2:30 p.m. His diagnoses included, but were not limited to anxiety.</p> <p>In review of the physician orders for Resident #E, a faxed communication from the facility to the attending physician, dated 8-1-16 at 1:15 p.m., indicated, "Resident was given wrong drug. Was given klonopin .5 mg [milligrams]. Was suppose to get alprazolam 1 mg prn [as needed]." The undated response from the attending physician indicated, "Noted. Try to avoid this in the future." On 8-2-16 was a notation in the clinical record from the attending physician which indicated, "No harm done, same [drug] class and action."</p> <p>In an interview with the Administrator on 8-9-16 at 3:25 p.m., she indicated the medication error was related to another resident with the same first and last name as Resident #E, with only their middle initials being different. The other resident resided on the skilled nursing portion of the facility. She indicated the other resident had "an order for Klonopin. The pharmacy did not put their middle initials on their medicine boxes. So, that is how [name of Resident #E] received the Klonopin. The doctor was notified immediately."</p>			

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	<p>Review of the medication orders for Resident #E indicated on 4-29-16, an order for alprazolam 1 mg by mouth three times daily as needed for anxiety. His physician orders did not include any orders for klonopin. Both medications are used in the treatment of anxiety.</p> <p>On 8-9-16 at 4:10 p.m., the Administrator provided a copy of a policy entitled, "Medication Administration-General Guidelines, " with an effective date of January, 2007. This policy indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication...Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label three times. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are administered in accordance with written orders of the attending physician..."</p>			

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	<p>On 8-9-16 at 4:10 p.m., the Administrator provided a copy of a policy entitled, "Medication/Treatment Error Administration Policy," with a revision date of July, 2015. This policy indicated, "This policy has been established to enable the facility to adopt a consistent approach in responding to medication and treatment administration errors. A facility medication/treatment error occurs when: a prescribed medication is not administered...the wrong medication is administered...failure to compare doctor's orders with pharmacy labels and medication administration record..."</p> <p>The "Nursing 2014 Drug Handbook," identifies "The eight 'rights' of medication administration," as the following:</p> <ol style="list-style-type: none"> <li>1. The right drug: Check the drug label and verify that the drug and form to be given is the drug that was prescribed.</li> <li>2. The right patient: Confirm the patient's identity by checking two patient identifiers.</li> <li>3. The right dose: Verify that the dose and form to be given is appropriate for the patient, and check the drug label with the prescriber's order.</li> <li>4. The right time: Ensure that the drug is administered at the correct time and frequency.</li> </ol>			

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R 0246  Bldg. 00	<p>5. The right route: Verify that the route by which the drug is to be given is specified by the prescriber and is appropriate for the patient...</p> <p>6. The right reason: Verify that the drug prescribed is appropriate to treat the patient's condition.</p> <p>7. The right response: Monitor the patient's response to the drug administered.</p> <p>8. The right documentation: Completely and accurately document in the patient's medical record the drug administered, the monitoring of the patient, including his response, and other nursing interventions."</p> <p>This Residential tag relates to Complaint IN00200504.</p> <p>5-4(e)(2)</p> <p>410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the</p>						

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	<p>contact. Based on interview and record review, the facility failed to ensure a QMA administering prn (as needed) medications had received authorization prior to the administering of a prn medication, which in turn was an incorrect medication for 1 of 3 residents reviewed for medication administration accuracy. (Resident #E)</p> <p>Findings include:</p> <p>Resident #E's clinical record was reviewed on 8-9-16 at 2:30 p.m. His diagnoses included, but were not limited to anxiety.</p> <p>In review of the physician orders for Resident #E, a faxed communication from the facility to the attending physician, dated 8-1-16 at 1:15 p.m., indicated, "Resident was given wrong drug. Was given klonopin .5 mg [milligrams]. Was suppose to get alprazolam 1 mg prn [as needed]." The undated response from the attending physician indicated, "Noted. Try to avoid this in the future." On 8-2-16 was a notation in the clinical record from the attending physician which indicated, "No harm done, same [drug] class and action."</p>	R 0246	<p>The facility does ensure medications are administered as ordered. Resident E's family and MD were notified 8/1/16 per the Physician notification policy. The facility is placing an alert sticker on all medications for residents with sound alike names. An audit was completed to identify any other residents with sound alike names to determine if stickers are needed. All nurses will be in-serviced by 9-8-16 on proper medication pass and the scope of practice for a QMA. The DON or designee will monitor three random medication passes per week for four weeks, then monthly for a total of six months to ensure continued compliance. Any negative findings will be reported to QAPI who will determine the need for further monitoring.</p>	09/08/2016			

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	<p>In an interview with the Administrator on 8-9-16 at 3:25 p.m., she indicated the medication error was related to another resident with the same first and last name as Resident #E, with only their middle initials being different. The other resident resided on the skilled nursing portion of the facility. She indicated the other resident had "an order for Klonopin. The pharmacy did not put their middle initials on their medicine boxes. So, that is how [name of Resident #E] received the Klonopin. The doctor was notified immediately."</p> <p>Review of the medication orders for Resident #E indicated on 4-29-16, an order for alprazolam 1 mg by mouth three times daily as needed for anxiety. His physician orders did not include any orders for klonopin. Both medications are used in the treatment of anxiety.</p> <p>Review of the clinical record failed to indicate the QMA had sought the approval of a licensed nurse at the facility prior to administering the klonopin to Resident #E.</p> <p>In an interview with the Administrator on 8-9-16 at 5:35 p.m., she indicated, "I could not find anything in the chart that showed there was any co-signing by a nurse for the prn on [name of Resident</p>			

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	<p>#E]. I could not find any particular policy or procedure about the QMA needing to get a licensed nurse approval before giving a prn. I would assume that would fall under the QMA 's scope of practice."</p> <p>On 8-9-16 at 4:10 p.m., the Administrator provided a copy of a policy entitled, "Medication Administration-General Guidelines, " with an effective date of January, 2007. This policy indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication...Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) is compared with the medication label three times. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule...Medications are administered in accordance with written orders of the attending physician..."</p> <p>On 8-9-16 at 4:10 p.m., the Administrator</p>			

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	<p>specified by the prescriber and is appropriate for the patient...</p> <p>6. The right reason: Verify that the drug prescribed is appropriate to treat the patient's condition.</p> <p>7. The right response: Monitor the patient's response to the drug administered.</p> <p>8. The right documentation: Completely and accurately document in the patient's medical record the drug administered, the monitoring of the patient, including his response, and other nursing interventions."</p> <p>This Residential tag relates to Complaint IN00200504.</p> <p>5-4(e)(6)</p>				