STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00182446. Complaint IN00182446 - Substantiated. Federal/State deficiency related to the allegations is cited at F 333. Survey dates: 9/28/15-9/29/15 Facility number: 000538 Provider number: 155620 AIM number: 100267290 Census bed type: SNF: 13 SNF/NF: 128 Residential: 43 Total: 184 Census payor type: Medicare: 16 Medicaid: 105 Other: 20 Total: 141 Sample: 6 This deficiency reflects state findings in accordance with 410 IAC 16.2-3.1.	F 0000		
F 0333	483.25(m)(2)			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
SS=G Bldg. 00	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 1 of 3 residents having medication errors did not experience signs or symptoms of distress resulting in hospitalization in a sample of 6 residents reviewed for medication administration (Residents B, C, D). Findings include: 1. The record for Resident B was reviewed on 9/28/15 at 11:00 a.m. Diagnoses included, but were not limited to, chronic leukocytic leukemia, chronic kidney disease, and dementia. A Nurse Practitioner (NP) note, dated 4/7/15, indicated she had been informed by the facility nurse that she had accidentally given Resident B another resident's medication, which included the drugs Decadron, Neurontin, and Oxycontin, and that Resident B normally only took PRN (as needed) Tylenol. The note indicated about 11:40 a.m. she was notified Resident B's O2 (oxygen) saturation had dropped to 78% (normal is greater than 90%). Oxygen was placed on the resident and he was given 0.4 mg (milligrams) of Narcan (antidote, opiod	F 0333	Thecreation and submission of this Plan of Correction does not constitute anadmission by this provider of any conclusion set forth in the statement ofdeficiencies, or any violation of regulation. This provider respectfully requests that the2567 Plan of Correction be considered the Letter of Credible Allegation and askfor a revisit on or after 10/19/2015. It is the practice of thisprovider to ensure that residents are free of any significant medicationerrors. **What correctiveaction(s) will be accomplished for those residents found to have been affectedby the alleged deficient practice** The resident of thisalleged deficient practice was immediately assessed for adverse effects. The Doctorand Family were notified immediately and resident was sent to ER forevaluation. Incident was reported to ISDH per facility policy. The nurseresponsible for alleged deficient practice was immediately re-educated on medicationpass procedure. **How will you identify other residents having the potential to beaffected by the alleged deficient practice and what corrective action will betaken** All residents have thepotential to be affected by the alleged	10/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
	antagonist) intramuscularly. The resident had minimal response to this, so 30 minutes later the NP started an IV and administered another 0.4 mg of Narcan. The resident opened his eyes to deep sternal rub but only briefly and his pupils remained pinpoint. The resident was then transferred to the emergency department via 911 and the NP called report to the hospital. The NP note also indicated Resident B was stable at the time of transfer and she had discussed this with the physician. A Nursing Note, dated 4/7/15 at 2:56 p.m. indicated the resident had been alert at the time of the medication error, the NP had been informed and had assessed him at that time. He was placed on 15 minute checks and vital signs every 30 minutes. When his O2 saturation dropped the NP was informed again and he was placed on oxygen by mask at 5 liters/minute. He had become lethargic as the morning progressed, and remained lethargic after oxygen and Narcan were provided. The resident was transported to the hospital about 12:30 p.m. The emergency department history, 4/7/15, indicated he had been given another resident's medication at the nursing facility, which included Oxycontin (opiod analgesic) 200 mg,		deficient practice. All licensed nurseswere provided education by the Clinical Education Coordinator or designee regardingthe Medication Pass procedure after alleged incident occurred. **What measures will be put into place or whatsystemic changes you will make to ensure that the deficient practice does notrecur**? · All licensed nurses willcomplete the Medication Pass Skills Validation during orientation and theClinical Education Coordinator or designee will ensure competency withmedication pass procedure prior to licensed nurse taking an independentassignment. Alllicensed nurses will be re-checked off by the Clinical Education Coordinator ordesignee on Medication Pass Procedure on or before 10/15/2015. All licensed nurses willbe re-educated on proper medication pass procedure, including the five right ofmedication administration on or before 10/15/2015. **How thecorrective action will be monitor to ensure the deficient practice will notrecur i.e. what quality assurance program will be put into place to ensurecompliance** The Medication Pass Skills Validation willbe completed on each shift by the Clinical Education Coordinator/designeeweekly x 4 weeks, monthly x 6 months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
	gabapentin (anticonvulsant) 100 mg, and dexamethasone (corticosteroid) 2 mg. The resident was lethargic on arrival in the emergency department. Narcan was administered and he opened his eyes and smiled. The emergency department plan indicated he was being admitted to the intensive care unit (ICU) and monitor his respiratory and mental status closely. The note indicated "Overall, critically ill and his condition can deteriorate further." He was admitted to the ICU, had a Narcan drip, and his somnolence resolved. Hospital records indicated on 4/8/15 he was transferred to the Medicine floor and therapy was started. The resident was discharged back to the facility on 4/14/15. The hospital discharge summary on 4/14/15 indicated he was alert and oriented to self, not location or time, but pleasant and cooperative, following commands. The resident was breathing comfortably on room air. 2. The record for Resident C was reviewed on 9/29/15 at 10:30 a.m. Her diagnoses included, but were not limited to, osteomyelitis.		then quarterly thereafter. The Medication Error CQI will be completed bythe Director of Nursing weekly x 4 weeks, monthly x 6 months and then quarterlythereafter. Data will be collected by DNS/designee at the monthly CQI teammeetings. If the 100% threshold is not met, an action plan will be developed. Quarterlyrefresher in-services will be conducted on the policy for Medication PassProcedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
	A Medication Error Report, dated 8/11/15 at 2:30 p.m. indicated Resident C had received a wrong medication. A physician's order, dated 8/2/15, indicated she was to receive Vancomycin 750 mg IV every 12 hours. A pharmacy dosage recommendation, dated 8/6/15, indicated her serum creatinine had increased to 2.0 mg on 8/6/15. The recommendation was to hold the Vancomycin doses until more laboratory work was done on 8/7/15. A physician's order, dated 8/7/15, indicated the Vancomycin was to be discontinued, daily blood work should be done, and she was started on an oral antibiotic. The physician was notified of the medication error on 8/11/15 and ordered another laboratory test. No signs or symptoms of distress or side effects were noted in the Nursing Progress Notes on 8/11/15, 8/12/15 or 8/13/15. The creatinine level that had been drawn on 8/10/15 was 1.6 (normal 0.6 to 1.3), on 8/12/15 the level was 1.7, and the next one was 8/19/15 and that result was 1.0.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
	3. The record for Resident D was reviewed on 9/28/15 at 10:55 a.m. Her diagnoses included, but were not limited to, rheumatoid arthritis and joint contracture. A health care plan, dated 12/16/14, indicated a problem was pain. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 7/28/15, indicated Resident D was to receive Vicodin 5-300 mg at every bed time. A Medication Error Report, dated 9/19/15, indicated Resident D had not received the Vicodin at bedtime during the month of September, 2015, to that date. The Narcotic sign out sheet does not show any Vicodin being signed out until 1 as needed dose was signed out on 9/15/15. The September, 2015, MAR (Medication Administration Record) indicated no Vicodin had been administered. The Nursing Notes from September 1, 2015, through September 19, 2015, do			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
	not indicate the resident had any complaints of pain or discomfort except on 9/15/15 when she had complained of groin pain after having a procedure. During an interview with the DNS (Director of Nursing Services) on 9/29/15 at 12:05 p.m., she indicated there were 5 nurses involved in missing the Vicodin doses for Resident D, and they all had indicated they had missed the order. On 9/29/15 at 2:30 p.m., the DNS indicated the nurse administering the Vancomycin hadn't looked at the MAR to see it was discontinued before she administered it. On 9/29/15 at 12:25 p.m., the DNS indicated her expectation was the nursing staff would look at the MAR for order changes before giving medication as well as reading the MAR during medication set up, and they were to follow the 5 Rights. A current facility policy, dated 11/02 and last revised 1/6/15, titled "Medication Errors" was provided by the DNS on 9/29/15 at 10:00 a.m. The policy indicated: "It is the policy of this provider to ensure residents residing in the facility are free of medication errors..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	09/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN 46077

(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
	A form, titled Medication Pass Procedure" dated 2/2010, was provided by the DNS on 9/29/15 at 10:00 a.m. and identified as the medication policy. It indicated: "...2. Medications checked 3 times to verify order with label.... 6. Identified resident prior to administering.... 17. Medication administration will be recorded on the MAR...after given...." This federal tag relates to Complaint IN00182446. 3.1-48(c)(2)			