STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF FORT WAYNE	7125 S HANNA STREET, FORT WAYNE, , 46816

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00372085 and IN00373616. Complaint IN00372085 Substantiated. No deficiencies related to the allegations are cited. Complaint IN00373616 - Substantiated. Deficiencies related to the allegations are cited at R0241, R0242, and R0297. Survey dates: March 2, 3, and 4, 2022 Facility number: 014316 Residential Census: 100 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 9, 2022	R 0000		

R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (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. Based on interview and record review the facility failed to follow the physician's order when administering medication for 1 of 3 residents reviewed. This resulted in a critically high Digoxin level. (Resident C) Findings include: Review of Resident C's record on 3/3/2022 at 2:00 P.M. indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease, essential (primary) hypertension, presence of a cardiac pacemaker, and unspecified atrial fibrillation. A review of Resident C's Level of Care Assessment, dated 2/22/22, indicated the resident required a caregiver for administration & observation of medication. A review of physician orders	R 0241	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Only one resident was affected. Resident lab testing was completed 2/17/22. Digoxin order 0.25mg held until further notice. Facility resident was tested again on 2/23/22. NP reviewed the follow up lab results at 0.70. NP gave orders to restart Digoxin 0.25mg once daily. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Facility takes weekly PTINR readings of all residents with orders for Coumadin. For residents with orders for Digoxin, facility ensures pulse is taken before administering. Facility will ensure that QMAs and nurses are checking the orders and verifying the order matches the medication to be administered. Facility will complete audit to ensure all MD orders match	04/29/2022

	dated 7/12/2021, indicated to give digoxin tablet, 0.25 mg (milligrams) by mouth one time a day related to unspecified atrial fibrillation, the order indicated the following: give 0.125 mg, 2 tabs (tablets) by mouth once daily, and to hold for a pulse of less than 60. A review of Resident C's Service Plan, dated 12/7/21 indicated under Medications, the resident would be supported to take all medications safely and as ordered. A review of a progress note dated 2/16/22, by RN 6 indicated communication with NP (Nurse Practitioner) included the facility had received a call from Pharmacy regarding a med error potentially affecting Resident C. A Digoxin order reading- Digoxin 0.25 mg- take 1 tab by mouth once daily for atrial fib (give 0.125 mg give 2 tabs by mouth once daily) had been misread by the pharmacy. The pharmacy had sent 3- 0.25 mg tabs in sure med packs 2 weeks. The pharmacy indicated the resident had been receiving he medication (three times the dose). The NP was notified and gave a new STAT order to draw Digoxin Levels. The nurse indicated she wrote on the med card with permanent marker to give only 1 tab & check dose. A review of a progress note		medications and that no other residents have the potential to be affected. If any inaccuracies are found, they will be immediately corrected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** All staff will be in-serviced on answering the phone. Lab will be provided emergency contact numbers for ED and DONW to call if community is not responding. Clinical staff to be inserviced on Digoxin toxicity sign and symptoms, reconciliation of medications and MD orders at time of med check-in, timely communication with MDs on status, and follow through of MD orders including labs. Facility will review and educate staff on incident reporting policy and procedure including reporting and pertinent charting. Facility will complete audit to ensure all MD orders match medications. **How will the corrective action be monitored to**	

	dated 2/17/22, indicated RN 6 had communicated with the NP (Nurse Practitioner), the new med card had been corrected by pharmacy, but the STAT lab had not been completed. She called the facility lab to report the miss and the NP reordered the STAT lab. A review of progress notes dated 2/17/22 at 5:48 P.M., by RN 11, indicated the lab had arrives to draw the digoxin level. A review of a laboratories instant stat report, dated 2/17/22, indicated Resident C's Digoxin level was collected on 2/17/22 5:44 P.M., and the result was critical 2.6, (therapeutic range 0.9-2.0 ng/ml (nanogram/milliliter). The report indicated a level was potentially toxic if greater than 2.5 ng/ml. The document indicated the laboratory staff tried three times to call the panic result to the facility, left two voicemails, but there was no call back. The laboratory staff tried to call the ordering physician, called the operator for an on-call number, but there were no results. The laboratory staff could not call Resident C or their responsible party the resident was in a nursing home. The report also indicated all options to contact someone had been exhausted on 2/17/2022 at 9:47 P.M. A review of a progress note		**ensure the deficient practice will not recur?** Nursing documentation regarding med passes will be reviewed by QA committee monthly for six months as long as a 100% rate for no med errors is obtained. If a med error occurs, QA will continue reviewing monthly for 6 more months. Systemic changes will be completed by: All staff education will be completed by 4/29/2022. Medications/order audit will be completed by 4/29/22.	

	dated 2/18/22, indicated RN 6 had called the hospital to obtain lab levels. The digoxin level was reported critical at 2.6, she notified the NP and was given a new order to hold Resident C's digoxin and recheck the lab on 2/23/22. RN 6 informed the resident. A review of a progress note dated 2/18/22, by the NP indicated Resident C had an elevated dig (digoxin) level, had been getting Digoxin 0.75 mg but had 0.25 mg ordered. The note indicated Resident C had no chest palpitations, or chest pain, vital signs were stable, resident denied shortness of breath, nausea, vomiting, diarrhea, fever, or chills. The resident was assessed. Under Assessment/Plan, the note indicated the problem was elevated Digoxin level and the action was to hold the Digoxin, and a recheck was ordered. A review of progress note, dated 2/24/22, indicated the NP reviewed the follow up digoxin lab result, at 0.70. The NP gave a new order to resume Digoxin 0.25 mg once daily. During an interview on 3/2/2022 at 8:35 A.M., Qualified Medication Aide (QMA)7, indicated that medications are prepackaged by the pharmacy for each resident. Medications to be given during a specific			

	timeframe are packaged together with each medication, dose, and number of tablets printed on the package, if a medication was not in the package, it was on a separate card with the resident's name. QMA 7 indicated she compares the medication on the package and/or card with the orders before she opened the package and placed them in a med cup for the resident. QMA 7 indicated when the medication in the packages/card didn't match the order, she wouldn't administer it and would speak with the nurse. During an interview on 3/2/2022 at 9:20 A.M., QMA 5 indicated when she obtained a resident's medication, she checked the medication in the blister pack with the medication order before administering it. QMA 5 indicated when a medication does not match the order, she would not administer it until she clarified with the nurse. During an interview on 3/4/2022 at 11:10 A.M., R.N. (Registered Nurse) 6, indicated when passing medication to a resident, she first looked at the order, then checked the order against the med packet. When the medication packet contained too many tablets of a medication, she would recheck the order, write on the medication list attached to the			

	medication packet to give the ordered number of tablets of a medication. She would notify the pharmacy, DON & NP (Nurse Practitioner). RN 6 indicated when she noted a resident had received medication in a packet not the correct strength or number of tablets to be given, she would assess the resident, notify the NP for orders, monitor labs as ordered, notify the pharmacy an incorrect strength or number of pills were in the packet, and notify the DON. RN 6 indicated when a QMA came to her with a discrepancy between what was ordered and what was in the packet, she would check the order, notify the pharmacy of the error in the medication packet, then the resident would be given the medication as ordered. When a QMA reported the medication in the package was not what was ordered but had been administered as packaged, RN 6 indicated she would assess the resident, notify the NP, get further orders, notify the pharmacy that the medication was incorrect in the medication packet, and notify the DON. During an interview on 3/3/2022 at 11:20 A.M., the DON indicated the pharmacy dispensed the residents' medication in a "bubble" packet. The DON indicated when a medication was changed or discontinued, the nurse marked			

	the medication off, dated the medication sheet attached to the bubble pack and noted a new dose was to be taken from the supplied medication card. A review of a policy, titled Medication Error Incident Policy, revision date 8/11/18, provided by DON on 3/4/22 1:30 P.M., indicated under Procedure 3. If the medication error is a result of pharmacy error, the pharmacist shall be notified immediately, and a Medication Error Incident Report completed in the computer system and submitted to the executive Director and Chief Operating officer and under Documentation: 2. The medication error, and what is done, is to be documented on the back of the medication sheet. 3. Complete and pertinent notes shall be recorded each shift for at least 24 hours on any patient who has received the wrong medication. A review of a policy, titled Medication Administration Program Policy, revision date 6/15/18, provided by DON on 3/2/22 9:45 A.M., indicated, under Med 1107 Medication Administration Program, "The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment			

	administration program. The elements of an approved medication administration systems are as follows: ...2. Written policies related to medication assistance and administration are followed by licensed and unlicensed staff within their scope of practice. 5. Documentation in the medication record is complete and accurate a. Resident receives medication as prescribed." This State finding is related to Complaint IN00373616 Based on interview and record review the facility failed to follow the physician's order when administering medication for 1 of 3 residents reviewed. This resulted in a critically high Digoxin level. (Resident C) Findings include: Review of Resident C's record on 3/3/2022 at 2:00 P.M. indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease, essential (primary) hypertension, presence of a cardiac pacemaker, and unspecified atrial fibrillation.			

	A review of Resident C's Level of Care Assessment, dated 2/22/22, indicated the resident required a caregiver for administration & observation of medication. A review of physician orders dated 7/12/2021, indicated to give digoxin tablet, 0.25 mg (milligrams) by mouth one time a day related to unspecified atrial fibrillation, the order indicated the following: give 0.125 mg, 2 tabs (tablets) by mouth once daily, and to hold for a pulse of less than 60. A review of Resident C's Service Plan, dated 12/7/21 indicated under Medications, the resident would be supported to take all medications safely and as ordered. A review of a progress note dated 2/16/22, by RN 6 indicated communication with NP (Nurse Practitioner) included the facility had received a call from Pharmacy regarding a med error potentially affecting Resident C. A Digoxin order reading- Digoxin 0.25 mg- take 1 tab by mouth once daily for atrial fib (give 0.125 mg give 2 tabs by mouth once daily) had been misread by the pharmacy. The pharmacy had sent 3- 0.25 mg tabs in sure med packs 2 weeks. The pharmacy indicated the resident had been receiving he medication (three times the			

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	Resident C or their responsible party the resident was in a nursing home. The report also indicated all options to contact someone had been exhausted on 2/17/2022 at 9:47 P.M. A review of a progress note dated 2/18/22, indicated RN 6 had called the hospital to obtain lab levels. The digoxin level was reported critical at 2.6, she notified the NP and was given a new order to hold Resident C's digoxin and recheck the lab on 2/23/22. RN 6 informed the resident. A review of a progress note dated 2/18/22, by the NP indicated Resident C had an elevated dig (digoxin) level, had been getting Digoxin 0.75 mg but had 0.25 mg ordered. The note indicated Resident C had no chest palpitations, or chest pain, vital signs were stable, resident denied shortness of breath, nausea, vomiting, diarrhea, fever, or chills. The resident was assessed. Under Assessment/Plan, the note indicated the problem was elevated Digoxin level and the action was to hold the Digoxin, and a recheck was ordered.			

	A review of progress note, dated 2/24/22, indicated the NP reviewed the follow up digoxin lab result, at 0.70. The NP gave a new order to resume Digoxin 0.25 mg once daily. During an interview on 3/2/2022 at 8:35 A.M., Qualified Medication Aide (QMA)7, indicated that medications are prepackaged by the pharmacy for each resident. Medications to be given during a specific timeframe are packaged together with each medication, dose, and number of tablets printed on the package, if a medication was not in the package, it was on a separate card with the resident's name. QMA 7 indicated she compares the medication on the package and/or card with the orders before she opened the package and placed them in a med cup for the resident. QMA 7 indicated when the medication in the packages/card didn't match the order, she wouldn't administer it and would speak with the nurse. During an interview on 3/2/2022 at 9:20 A.M., QMA 5 indicated when she obtained a resident's medication, she checked the medication in the blister pack with the medication order before administering it. QMA 5 indicated when a medication does not match the order, she would not administer it until she			

clarified with the nurse.

During an interview on 3/4/2022 at 11:10 A.M., R.N. (Registered Nurse) 6, indicated when passing medication to a resident, she first looked at the order, then checked the order against the med packet. When the medication packet contained too many tablets of a medication, she would recheck the order, write on the medication list attached to the medication packet to give the ordered number of tablets of a medication. She would notify the pharmacy, DON & NP (Nurse Practitioner). RN 6 indicated when she noted a resident had received medication in a packet not the correct strength or number of tablets to be given, she would assess the resident, notify the NP for orders, monitor labs as ordered, notify the pharmacy an incorrect strength or number of pills were in the packet, and notify the DON. RN 6 indicated when a QMA came to her with a discrepancy between what was ordered and what was in the packet, she would check the order, notify the pharmacy of the error in the medication packet, then the resident would be given the medication as ordered. When a QMA reported the medication in the package was not what was ordered but had been administered as packaged, RN 6 indicated she would assess

	the resident, notify the NP, get further orders, notify the pharmacy that the medication was incorrect in the medication packet, and notify the DON. During an interview on 3/3/2022 at 11:20 A.M., the DON indicated the pharmacy dispensed the residents' medication in a "bubble" packet. The DON indicated when a medication was changed or discontinued, the nurse marked the medication off, dated the medication sheet attached to the bubble pack and noted a new dose was to be taken from the supplied medication card. A review of a policy, titled Medication Error Incident Policy, revision date 8/11/18, provided by DON on 3/4/22 1:30 P.M., indicated under Procedure 3. If the medication error is a result of pharmacy error, the pharmacist shall be notified immediately, and a Medication Error Incident Report completed in the computer system and submitted to the executive Director and Chief Operating officer and under Documentation: 2. The medication error, and what is done, is to be documented on the back of the medication sheet. 3. Complete and pertinent notes shall be recorded each shift for at least 24 hours on any patient who has received the wrong			

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R 0242	Health Services - Offense 410 IAC 16.2-5-4(e)(2) (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and	R 0242	**What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** Only one resident was affected. Resident lab testing was completed 2/17/22.	04/29/2022

	such notification shall be documented in the clinical record. Based on interview and record review the facility failed to monitor 1 of 1 resident for side effects related to a critically elevated digoxin level. (Resident C) Findings include: Review of Resident C's record on 3/3/2022 at 2:00 P.M. indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease, essential (primary) hypertension, presence of a cardiac pacemaker, unspecified atrial fibrillation. A review of Resident C's Level of Care Assessment, dated 2/22/22, indicated the resident required a caregiver for administration & observation of medication. A review of physician orders, dated 7/12/2021, indicated an order to give digoxin tablet, 0.25 mg(milligrams) by mouth one time a day related to unspecified atrial fibrillation. The ordered continued, give 0.125 mg - 2 tabs (tablets) by mouth once daily, and to hold for a pulse of less than 60. A review of the Service Plan Detail, dated 12/7/21 indicated under the Medications section		Digoxin order 0.25mg held until further notice. Facility resident was tested again on 2/23/22. NP reviewed the follow up lab results at 0.70. NP gave orders to restart Digoxin 0.25mg once daily. **How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** Facility takes weekly PTINR readings of all residents with orders for Coumadin. For residents with orders for Digoxin, facility ensures pulse is taken before administering. Facility will ensure that QMAs and nurses are checking the orders and verifying the order matches the medication to be administered. Nursing/Administration will perform weekly audits using ADMINISTRATION AND DOCUMENTATION OF MEDICATIONS OBSERVATION AUDIT tool for 6 weeks. Facility will complete audit to ensure all MD orders match medications and that no other residents have	

	the resident would be supported to take all medications safely and as ordered. A review of a progress note dated 2/16/22, by RN 6 indicated the facility had received a call from the pharmacy regarding a med error. Resident C had an order to give Digoxin 0.25 mg- take 1 tab by mouth once daily for A Fib, give 0.125 mg - 2 tabs by mouth once daily. The pharmacy had been sending 3-0.25 mg tabs in med packs for 2 weeks. The NP was notified and a new order for a STAT digoxin level was received. The nurse wrote on the med card with permanent marker to give only 1 tab and to check the dose. A review of Resident C's progress notes dated 2/17/22, indicated RN 6, informed the NP the medication pack had been corrected by the pharmacy, but the STAT lab had not been completed. She called the lab to report the missed lab and received a STAT lab reordered from the NP. A review of progress notes dated 2/17/22 at 5:48 P.M., indicated the lab was at the facility to draw the digoxin level. A review of a laboratory instant report stat, dated 2/17/22, indicated Resident C's digoxin level was collected on 2/17/22		the potential to be affected. If any inaccuracies are found, they will be immediately corrected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** All staff will be in-serviced on answering the phone. Lab will be provided emergency contact numbers for ED and DONW to call if community is not responding. Clinical staff to be inserviced on Digoxin toxicity sign and symptoms, reconciliation of medications and MD orders at time of med check-in, timely communication with MDs on status, and follow through of MD orders including labs. Facility will review and educate staff on incident reporting policy and procedure including reporting and pertinent charting. Facility will complete audit to ensure all MD orders match medications.	

	at 5:44 P.M., the result was critical 2.6, (therapeutic range 0.9-2.0 ng/ml (nanogram/milliliter) and a level was potentially toxic if greater than 2.5 ng/ml. The document indicated the laboratory staff tried three times to call the panic result to the facility, left two voicemails with no call back. The laboratory staff tried to call the ordering physician, and called the operator for an on-call number, but there were no results. The laboratory staff could not call the resident or responsible party. The report indicated per the lab's procedure all options had been exhausted. 2/17/2022 9:47" A review of progress note dated 2/18/22, created by RN 6 indicated the RN 6 called the laboratory to obtain lab levels. Digoxin level was reported critical at 2.6 (normal 0.9-2.0). NP was notified with new order to hold digoxin and recheck lab on Wednesday. RN 6 indicated resident aware. A review of progress notes dated 2/18/22, by the NP indicated Resident C had an elevated dig (digoxin) level. The resident had been getting Digoxin 0.75 mg but had been ordered 0.25 mg. the note indicated the resident had no chest palpitations, no chest pain, vital signs stable, denies shortness of breath, nausea,		**How will the corrective action be monitored to ensure the deficient practice will not recur?** Nursing documentation regarding med passes will be reviewed by QA committee monthly for six months as long as a 100% rate for no med errors is obtained. If a med error occurs, QA will continue reviewing monthly for 6 more months. QA will review nursing audits until complete. Systemic changes will be completed by: All staff education will be completed by 4/29/2022. Medications/order audit will be completed by 4/29/22.	

vomiting, diarrhea, fever, or chills. The note indicated the problem was an elevated digoxin level. Orders were to hold the Digoxin, and a recheck was ordered.

Review of progress notes indicated Resident C was not monitored by nursing staff for signs or symptoms of digoxin toxicity, between 2/16/22 and 2/24/22.

During an interview on 3/2/2022 at 8:35 A.M., Qualified Medication Aide (QMA)7, indicated she didn't know there was a problem with Resident C the staff had to monitor.

During an interview on 3/4/2022 at 11:10 A.M., R.N. (Registered Nurse) 6, indicated when she received a critical lab result, she would notify the NP for orders, and monitor the resident. She indicated there was no note to monitor Resident C.

During an interview on 3/3/2022 11:20 A.M., the DON indicated residents should be monitored for side effects from medications.

A policy titled, Medication, Administration Program Policy, revision date 6/15/18, provided by DON on 3/2/22 9:45 A.M., indicated under Med 1107 Medication Administration Program, "The community Executive Director/Director of

Health and Wellness will ensure adequate professional oversight of the medication treatment administration program.

A policy, titled Medication Error Incident Policy, revision date 8/11/21, provided by DON on 3/4/22 1:30 P.M., indicated under Documentation: 2. The medication error and what is done, is to be documented on the back of the medication sheet. 3. Complete and pertinent notes shall be recorded each shift for at least 24 hours on any patient who has received the wrong medication.

This State findings is related to Complaint IN00373616.

Based on interview and record review the facility failed to monitor 1 of 1 resident for side effects related to a critically elevated digoxin level. (Resident C)

Findings include:

Review of Resident C's record on 3/3/2022 at 2:00 P.M. indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease, essential (primary) hypertension, presence of a cardiac pacemaker, unspecified atrial fibrillation.

A review of Resident C's Level of Care Assessment, dated

	2/22/22, indicated the resident required a caregiver for administration & observation of medication. A review of physician orders, dated 7/12/2021, indicated an order to give digoxin tablet, 0.25 mg(milligrams) by mouth one time a day related to unspecified atrial fibrillation. The ordered continued, give 0.125 mg - 2 tabs (tablets) by mouth once daily, and to hold for a pulse of less than 60. A review of the Service Plan Detail, dated 12/7/21 indicated under the Medications section the resident would be supported to take all medications safely and as ordered. A review of a progress note dated 2/16/22, by RN 6 indicated the facility had received a call from the pharmacy regarding a med error. Resident C had an order to give Digoxin 0.25 mg- take 1 tab by mouth once daily for A Fib, give 0.125 mg - 2 tabs by mouth once daily. The pharmacy had been sending 3-0.25 mg tabs in med packs for 2 weeks. The NP was notified and a new order for a STAT digoxin level was received. The nurse wrote on the med card with permanent marker to give only 1 tab and to check the dose. A review of Resident C's			

progress notes dated 2/17/22, indicated RN 6, informed the NP the medication pack had been corrected by the pharmacy, but the STAT lab had not been completed. She called the lab to report the missed lab and received a STAT lab reordered from the NP.

A review of progress notes dated 2/17/22 at 5:48 P.M., indicated the lab was at the facility to draw the digoxin level.

A review of a laboratory instant report stat, dated 2/17/22, indicated Resident C's digoxin level was collected on 2/17/22 at 5:44 P.M., the result was critical 2.6, (therapeutic range 0.9-2.0 ng/ml (nanogram/milliliter) and a level was potentially toxic if greater than 2.5 ng/ml. The document indicated the laboratory staff tried three times to call the panic result to the facility, left two voicemails with no call back. The laboratory staff tried to call the ordering physician, and called the operator for an on-call number, but there were no results. The laboratory staff could not call the resident or responsible party. The report indicated per the lab's procedure all options had been exhausted. 2/17/2022 9:47"

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	laboratory to obtain lab levels. Digoxin level was reported critical at 2.6 (normal 0.9-2.0). NP was notified with new order to hold digoxin and recheck lab on Wednesday. RN 6 indicated resident aware. A review of progress notes dated 2/18/22, by the NP indicated Resident C had an elevated dig (digoxin) level. The resident had been getting Digoxin 0.75 mg but had been ordered 0.25 mg. the note indicated the resident had no chest palpitations, no chest pain, vital signs stable, denies shortness of breath, nausea, vomiting, diarrhea, fever, or chills. The note indicated the problem was an elevated digoxin level. Orders were to hold the Digoxin, and a recheck was ordered. Review of progress notes indicated Resident C was not monitored by nursing staff for signs or symptoms of digoxin toxicity, between 2/16/22 and 2/24/22. During an interview on 3/2/2022 at 8:35 A.M., Qualified Medication Aide (QMA)7, indicated she didn't know there was a problem with Resident C the staff had to monitor. During an interview on 3/4/2022 at 11:10 A.M., R.N. (Registered Nurse) 6, indicated when she			

	received a critical lab result, she would notify the NP for orders, and monitor the resident. She indicated there was no note to monitor Resident C. During an interview on 3/3/2022 11:20 A.M., the DON indicated residents should be monitored for side effects from medications. A policy titled, Medication, Administration Program Policy, revision date 6/15/18, provided by DON on 3/2/22 9:45 A.M., indicated under Med 1107 Medication Administration Program, "The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program. A policy, titled Medication Error Incident Policy, revision date 8/11/21, provided by DON on 3/4/22 1:30 P.M., indicated under Documentation: 2. The medication error and what is done, is to be documented on the back of the medication sheet. 3. Complete and pertinent notes shall be recorded each shift for at least 24 hours on any patient who has received the wrong medication. This State findings is related to Complaint IN00373616.			

R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review the facility failed to ensure the pharmacy provided 1 of 3 residnets reviewed with medictions as ordered.(Resident C) Findings include: Review of Resident C's record on 3/3/2022 at 2:00 P.M. indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease, essential (primary) hypertension, presence of a cardiac pacemaker, and unspecified atrial fibrillation. A review of physician orders dated 7/12/2021, indicated to give digoxin tablet, 0.25 mg (milligrams) by mouth one time a day related to unspecified atrial fibrillation, the order indicated the following: give	R 0297	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? Resident lab testing was completed 2/17/22. Digoxin order 0.25mg held until further notice. Facility resident was tested again on 2/23/22. NP reviewed the follow up lab results at 0.70. NP gave orders to restart Digoxin 0.25mg once daily. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Facility takes weekly PTINR readings of all residents with orders for Coumadin. For residents with orders for Digoxin, facility ensures pulse is taken before administering.	04/29/2022

	0.125 mg, 2 tabs (tablets) by mouth once daily, and to hold for a pulse of less than 60. A review of a progress note dated 2/16/22, by RN 6 indicated communication with NP (Nurse Practitioner) included the facility had received a call from the pharmacy regarding a med error potentially affecting Resident C. A Digoxin order reading- Digoxin 0.25 mg- take 1 tab by mouth once daily for atrial fib (give 0.125 mg give 2 tabs by mouth once daily) had been misread by the pharmacy. The pharmacy had sent 3- 0.25 mg tabs in sure med packs 2 weeks. The pharmacy indicated the resident had been receiving the medication (three times the dose). The NP was notified and gave a new STAT order to draw Digoxin Levels. The nurse indicated she wrote on the med card with permanent marker to give only 1 tab & check dose. A review of a progress note dated 2/17/22, indicated RN 6 had communicated with the NP (Nurse Practitioner), the new med card had been corrected by pharmacy. A review of a laboratories instant stat report, dated 2/17/22, indicated Resident C's Digoxin level was collected on 2/17/22 5:44 P.M., and the result was critical 2.6, (therapeutic range 0.9-2.0 ng/ml		What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? All staff will be in-serviced on answering the phone. Lab will be provided emergency contact numbers for ED and DONW to call if community is not responding. Clinical staff to be inserviced on Digoxin toxicity sign and symptoms, reconciliation of medications and MD orders at time of med check-in, timely communication with MDs on status, and follow through of MD orders including labs. Facility will review and educate staff on incident reporting policy and procedure including reporting and pertinent charting. Facility will complete audit to	

	(nanogram/milliliter). The report indicated a level was potentially toxic if greater than 2.5 ng/ml. The document indicated the laboratory staff tried three times to call the panic result to the facility, left two voicemails, but there was no call back. The laboratory staff tried to call the ordering physician, called the operator for an on-call number, but there were no results. The laboratory staff could not call Resident C or their responsible party the resident was in a nursing home. The report also indicated all options to contact someone had been exhausted on 2/17/2022 at 9:47 P.M. A review of a progress note dated 2/18/22, indicated RN 6 had called the hospital to obtain lab levels. The digoxin level was reported critical at 2.6, she notified the NP and was given a new order to hold Resident C's digoxin and recheck the lab on 2/23/22. RN 6 informed the resident. A review of a progress note dated 2/18/22, by the NP indicated Resident C had an elevated dig (digoxin) level, had been getting Digoxin 0.75 mg but had 0.25 mg ordered. The note indicated Resident C had no chest palpitations, or chest pain, vital signs were stable, resident denied shortness of breath, nausea, vomiting, diarrhea, fever, or chills. The		ensure all MD orders match medications. President and VP of Clinical and VP of Operations will be having service discussions with current pharmacy in next two weeks. Will have new pharmacy provide consulting services. How will the corrective action be monitored to ensure the deficient practice will not recur? Nursing documentation will be reviewed by QA/safety committee. Systemic changes will be completed by: All staff education will be completed by 4/29/2022. Medications/order audit will be completed by 4/29/22.	

resident was assessed. Under Assessment/Plan, the note indicated the problem was elevated Digoxin level and the action was to hold the Digoxin, and a recheck was ordered.

A review of progress note, dated 2/24/22, indicated the NP reviewed the follow up digoxin lab result, at 0.70. The NP gave a new order to resume Digoxin 0.25 mg once daily.

During an interview on 3/2/2022 at 8:35 A.M., Qualified Medication Aide (QMA)7, indicated medications are prepackaged by the pharmacy for each resident. Medications to be given during a specific time frame are packaged together with each medication, dose, and number of tablets printed on the package, if a medication was not in the package, it was on a separate card with the resident's name. QMA 7 indicated she compares the medication on the package and/or card with the orders before she opened the package and placed them in a med cup for the resident. QMA 7 indicated when the medication in the packages/card didn't match the order, she wouldn't administer it and would speak with the nurse.

During an interview on 3/2/2022 at 9:20 A.M., QMA 5 indicated when she obtained a resident's

medication, she checked the medication in the blister pack with the medication order before administering it. QMA 5 indicated when a medication does not match the order, she would not administer it until she clarified with the nurse.

During an interview on 3/4/2022 at 11:10 A.M., R.N. (Registered Nurse) 6, indicated when passing medication to a resident, she first looked at the order, then checked the order against the med packet. When the medication packet contained too many tablets of a medication, she would recheck the order, write on the medication list attached to the medication packet to give the ordered number of tablets of a medication. She would notify the pharmacy, DON & NP (Nurse Practitioner). RN 6 indicated when she noted a resident had received medication in a packet not the correct strength or number of tablets to be given, she would assess the resident, notify the NP for orders, monitor labs as ordered, notify the pharmacy an incorrect strength or number of pills were in the packet, and notify the DON. RN 6 indicated when a QMA came to her with a discrepancy between what was ordered and what was in the packet, she would check the order, notify the pharmacy of the error in the medication packet, then the

resident would be given the medication as ordered. When a QMA reported the medication in the package was not what was ordered but had been administered as packaged, RN 6 indicated she would assess the resident, notify the NP, get further orders, notify the pharmacy that the medication was incorrect in the medication packet, and notify the DON.

During an interview on 3/3/2022 at 11:20 A.M., the DON indicated the pharmacy dispensed the residents' medication in a "bubble" packet. The DON indicated when a medication was changed or discontinued, the nurse marked the medication off, dated the medication sheet attached to the bubble pack and noted a new dose was to be taken from the supplied medication card.

A review of a policy, titled Medication Error Incident Policy, revision date 8/11/18, provided by DON on 3/4/22 1:30 P.M., indicated under Procedure 3. If the medication error is a result of pharmacy error, the pharmacist shall be notified immediately, and a Medication Error Incident Report completed in the computer system and submitted to the executive Director and Chief Operating officer and under Documentation: 2. The medication error, and what is

done, is to be documented on the back of the medication sheet. 3. Complete and pertinent notes shall be recorded each shift for at least 24 hours on any patient who has received the wrong medication.

A review of a policy, titled Medication Administration Program Policy, revision date 6/15/18, provided by DON on 3/2/22 9:45 A.M., indicated, under Med 1107 Medication Administration Program, "The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program. The elements of an approved medication administration systems are as follows: ...2. Written policies related to medication assistance and administration are followed by licensed and unlicensed staff within their scope of practice. 5. Documentation in the medication record is complete and accurate a. Resident receives medication as prescribed."

This State finding is related to Complaint IN00373616

Based on interview and record review the facility failed to ensure the pharmacy provided 1 of 3 residnets reviewed with

medictions as ordered.(Resident C)

Findings include:

Review of Resident C's record on 3/3/2022 at 2:00 P.M. indicated diagnoses included, but were not limited to, chronic obstructive pulmonary disease, essential (primary) hypertension, presence of a cardiac pacemaker, and unspecified atrial fibrillation.

A review of physician orders dated 7/12/2021, indicated to give digoxin tablet, 0.25 mg (milligrams) by mouth one time a day related to unspecified atrial fibrillation, the order indicated the following: give 0.125 mg, 2 tabs (tablets) by mouth once daily, and to hold for a pulse of less than 60.

A review of a progress note dated 2/16/22, by RN 6 indicated communication with NP (Nurse Practitioner) included the facility had received a call from the pharmacy regarding a med error potentially affecting Resident C. A Digoxin order reading- Digoxin 0.25 mg- take 1 tab by mouth once daily for atrial fib (give 0.125 mg give 2 tabs by mouth once daily) had been misread by the pharmacy. The pharmacy had sent 3- 0.25 mg tabs in sure med packs 2 weeks. The pharmacy indicated the resident had been receiving

the medication (three times the dose). The NP was notified and gave a new STAT order to draw Digoxin Levels. The nurse indicated she wrote on the med card with permanent marker to give only 1 tab & check dose.

A review of a progress note dated 2/17/22, indicated RN 6 had communicated with the NP (Nurse Practitioner), the new med card had been corrected by pharmacy.

A review of a laboratories instant stat report, dated 2/17/22, indicated Resident C's Digoxin level was collected on 2/17/22 5:44 P.M., and the result was critical 2.6, (therapeutic range 0.9-2.0 ng/ml (nanogram/milliliter). The report indicated a level was potentially toxic if greater than 2.5 ng/ml. The document indicated the laboratory staff tried three times to call the panic result to the facility, left two voicemails, but there was no call back. The laboratory staff tried to call the ordering physician, called the operator for an on-call number, but there were no results. The laboratory staff could not call Resident C or their responsible party the resident was in a nursing home. The report also indicated all options to contact someone had been exhausted on 2/17/2022 at 9:47 P.M.

A review of a progress note

dated 2/18/22, indicated RN 6 had called the hospital to obtain lab levels. The digoxin level was reported critical at 2.6, she notified the NP and was given a new order to hold Resident C's digoxin and recheck the lab on 2/23/22. RN 6 informed the resident.

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time frame are packaged together with each medication, dose, and number of tablets printed on the package, if a medication was not in the package, it was on a separate card with the resident's name. QMA 7 indicated she compares the medication on the package and/or card with the orders before she opened the package and placed them in a med cup for the resident. QMA 7 indicated when the medication in the packages/card didn't match the order, she wouldn't administer it and would speak with the nurse.

During an interview on 3/2/2022 at 9:20 A.M., QMA 5 indicated when she obtained a resident's medication, she checked the medication in the blister pack with the medication order before administering it. QMA 5 indicated when a medication does not match the order, she would not administer it until she clarified with the nurse.

During an interview on 3/4/2022 at 11:10 A.M., R.N. (Registered Nurse) 6, indicated when passing medication to a resident, she first looked at the order, then checked the order against the med packet. When the medication packet contained too many tablets of a medication, she would recheck the order, write on the medication list attached to the

medication packet to give the ordered number of tablets of a medication. She would notify the pharmacy, DON & NP (Nurse Practitioner). RN 6 indicated when she noted a resident had received medication in a packet not the correct strength or number of tablets to be given, she would assess the resident, notify the NP for orders, monitor labs as ordered, notify the pharmacy an incorrect strength or number of pills were in the packet, and notify the DON. RN 6 indicated when a QMA came to her with a discrepancy between what was ordered and what was in the packet, she would check the order, notify the pharmacy of the error in the medication packet, then the resident would be given the medication as ordered. When a QMA reported the medication in the package was not what was ordered but had been administered as packaged, RN 6 indicated she would assess the resident, notify the NP, get further orders, notify the pharmacy that the medication was incorrect in the medication packet, and notify the DON.

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	administration program. The elements of an approved medication administration systems are as follows: ...2. Written policies related to medication assistance and administration are followed by licensed and unlicensed staff within their scope of practice. 5. Documentation in the medication record is complete and accurate a. Resident receives medication as prescribed." This State finding is related to Complaint IN00373616			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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