STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 00 B. WING	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WILDWOOD HEALTHCARE CENTER	7301 E 16TH ST INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 IN00388107. Complaint IN00388107 - Substantiated. Federal/state deficiencies related to the allegations are cited at F760 Survey dates: August 31, 2022 Facility number: 000227 Provider number: 155334 AIM number: 100267520 Census Bed Type: SNF/NF:146 Total: 146 Census Payor Type: Medicare: 9 Medicaid: 105 Other: 32 Total: 146 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 1, 2022	F 0000	On August 31, 2022 a complaint Surveyor from ISDH completed a Complaint Survey at Wildwood Healthcare. Enclosed please find the stated list of deficiencies with the facility's plan of correction for these alleged deficiencies. Please consider this letter and plan of correction to be the facility's credible allegation of compliance. This letter is our request for a desk review/ paper compliance to verify the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the plan of correction as September 19, 2022 Respectfully Ethan Peak, Executive Director	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident was free of a significant medication error for 1 of 3 residents reviewed for medication administration. (Resident B)	F 0760	1) 1. Resident B did not sustain any harm from the deficient practice and discharged from the facility per his plan of	09/19/2022

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

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	Findings include: The clinical record for Resident B was reviewed on 8/31/22 at 11:12 a.m. Resident B's diagnoses included, but not limited to, hypertension and chronic viral hepatitis C. Resident B's quarterly MDS (minimum data set) dated 7/19/22 indicated, they were unable to complete the interview used to assess cognition. A physician's order dated 4/20/22 indicated, to administer 100 mg(milligrams) of amantadine HCL(sic, hydrochloride) solution 50 mg/5 ml (medication for treatment of movement disorders like Parkinson's disease, 50 milligrams per 5 milliliters) by mouth two times a day for health maintenance. A Convergence Consultation note dated 8/12/22 at 6:59 p.m. indicated, Resident B received a medication error and was to receive 100 mg of amantadine which was supplied as a solution of 50 mg per 5 ml. Resident B should have received a total of 10 ml instead, he received 100 ml which was 1000 mg. A Convergence Consultation note dated 8/12/22 at 7:11 p.m. indicated, Resident B was to be transferred to the emergency room for further evaluation. An interview with Resident B's family member (FM) was conducted on 8/31/22 at 11:03 a.m. They indicated, they had received a call from the facility on 8/12/22 at approximately 7 p.m. indicating their father was being sent to the local emergency room because he received an overdose of the amantadine. They stated, the hospital kept		care. 2) 2. All residents have the potential to be affected by the deficient practice. A review of the last 7 days of medication administration was completed with no significant medication errors noted. A review of liquid medications ordered in facility was completed and any order with directions in milligrams was updated to milliliters. 3) 3. All qualified medication aides were educated on facilities “Medication Administration Policy” with an emphasis on ensuring each medication administered is checked for the correct dosage. A med pass competency was completed with all qualified medication aides. 4) 4. Director of nursing or designee will observe 3 medication passes with qualified medication aides weekly x 4 weeks, then 1 medication pass weekly x 4 weeks, then 2 medication passes monthly x 4 months. Qualified medication aides will continue with their ongoing education on medication administration. Results of the audit will be brought to QA for 6 months or until 100% compliance has been achieved.	

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	their father for observation related to possible side effects from the overdose. AHFS Patient Medication Information [Internet]. Bethesda (MD): American Society of Health-System Pharmacists, Inc.; c2019. amantadine last accessed 9/1/22; Available from: https://medlineplus.gov/druginfo/meds/a604025.html indicated, "Symptoms of overdose may include the following: irregular or fast heartbeat difficulty breathing decreased urination swelling of the hands, feet, ankles or lower legs stiff or rigid arms or legs uncontrollable movements or shaking of a part of the body problems with coordination confusion feeling like you are looking at yourself as an outside observer fear, irritability, or aggressive behavior seeing things or hearing voices that do not exist lack of energy" The investigation file regarding the medication error was received on 8/31/22 at 1:43 p.m. from ED (Executive Director). The investigation file contained, but not limited to, a handwritten statement from QMA 1 dated 8/12/22 indicated, on 8/12/22 at approximately 6:30 p.m. she had made a medication error. She had read the order as "100 ml and mistakenly poured 100 ml and gave it to [sic, Resident B's name]. I returned to the nurses cart to click off the medication and that's when my brain decided to make the connection that what I just gave him was way wrong....I quickly contacted [sic, charge nurse's name], the charge nurse about my error..."			

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	An interview with QMA (Qualified Medication Aide) 1 conducted on 8/31/22 at 1:36 p.m. indicated, she was the QMA who had administered Resident B the amantadine on 8/12/22. QMA 1 indicated, when she read the label on the bottle of amantadine she thought it had said to give 100 ml rather than 100 mg. QMA 1 stated, "My mind said milliliters and not milligrams". QMA 1 indicated, she was not familiar with the medication prior to administering it to Resident B. A Medication Incident policy was received on 8/31/22 at 11:07 a.m. from DON (Director of Nursing). The policy indicated, "The purpose of this policy is to provide guidance administering medications in a safe and timely manner and as ordered for that resident. CMS [sic, Center for Medicare and Medicaid] defines a medication error as the preparation or administration of medications or biologicals that is not in accordance with any of the following: 1. The prescriber's order (whether given incorrectly or omitting an ordered dosage) 2. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological 3. Accepted professional standards and principles that apply to professional providing services...In order to accomplish the 5 Rights of Medication Administration, labels must be accurately read and instructions followed for that medication." This Federal tag is related to complaint IN00388107. 3.1-48(c)(2) 3.1-25(b)(9)			