STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE - VICTORY NOLL	25 VICTORY NOLL DRIVE HUNTINGTON, IN 46750

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00410414. Complaint IN00410414 - State deficiencies related to the allegations are cited at R0247. Survey date: June 15, 2023. Facility number: 013978 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed June 20, 2023.	R 0000	Plan of correction as follows: DON to provide reeducation to Nurses of proper practice and procedures on Medication administration and Medication Errors per Saint Anne Communities Policies. DON will be updating Medication Error forms to ensure better documentation is completed on each shift with vital signs per policy and best practices. Moving forward once DON is notified of Errors, she will follow up that all parties have been notified in timely manner and documentation is completed.	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to notify the physician, and monitor the resident, after a medication error for 1 of 3 residents reviewed for medication errors. (Resident B) Findings include:	R 0247	Plan of correction as follows: DON to provide reeducation to Nurses of proper practice and procedures on Medication administration and Medication Errors per Saint Anne	07/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kayla Winters	Administrator in Training	07/07/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE - VICTORY NOLL	25 VICTORY NOLL DRIVE HUNTINGTON, IN 46750

(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
	Resident B's clinical record was reviewed on 6/15/23 at 9:48 a.m. Diagnoses included hypertension, hyperlipidemia, and chronic obstructive pulmonary disease. Her current medications included acetaminophen (pain reliever) 1000 mg (milligram) twice daily, acidophilus (digestive health) daily, amlodipine (blood pressure) 10 mg daily, aspirin (blood thinner) 81 mg daily, atorvastatin (high cholesterol) 40 mg daily, certrizine (allergies) 10 mg daily, daily multivitamin, docusate sodium (stool softener) 200 mg daily, doxazosin (blood pressure) 2 mg daily, losartan (blood pressure) 100 mg twice daily, melatonin (sleep) daily, pantoprazole (acid reflux) 20 mg daily, potassium chloride (supplement) 20 meq (milliequivalents) daily, primidone (seizures) 50 mg daily, sertraline (depression) 150 mg daily, spironolactone (blood pressure) 25 mg daily, and torsemide (blood pressure) 20 mg daily. Review of a Medication Error Report, completed by LPN 15, indicated a medication occurred on 6/2/23, during the morning medication pass. Resident B reported to LPN 15 she took medication intended for another resident (Resident D) that morning. Resident D's clinical record was reviewed on 6/15/23 at 10:00 a.m. His ordered morning medications included docusate sodium 100 mg, Eliquis (blood thinner) 5 mg, finasteride (prostate) 5 mg, furosemide (blood pressure) 20 mg, multivitamin, potassium chloride 10 meq, and senna (laxative) 17.2 mg. The DON was notified on 6/2/23 at approximately 9:30 p.m., Resident B's family was notified of the		Communities Policies. DON will be updating Medication Error forms to ensure better documentation is completed on each shift with vital signs per policy and best practices. Moving forward once DON is notified of Errors, she will follow up that all parties have been notified in timely manner and documentation is completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE - VICTORY NOLL	25 VICTORY NOLL DRIVE HUNTINGTON, IN 46750

(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
	error on 6/2/23 at 10:00 p.m., and the nurse practitioner was notified on 6/2/23 at 11:00 p.m., with no recommendations documented. During an interview with LPN 15, on 6/15/23 at 11:02 a.m., she indicated on 6/2/23 at approximately 9:25 p.m., Resident B reported to her she had taken the wrong medication that morning. Resident B appeared fine and she proceeded to follow the facility guidelines. She was not told in report, during shift change, of the error. LPN 15 reported the error to the nurse practitioner and he indicated Resident B would be okay with monitoring, so she obtained her vital signs. During an interview with LPN 9, on 6/15/23 at 11:10 a.m., she indicated she just wasn't being careful. She set up two medications for two residents and gave them the wrong medication. She gave Resident B Resident D's medication. When she offered Resident D Resident B's medication, he noticed he had the wrong medication and the wrong initials were on the medication cup. She went back to grab the medication from Resident B, but she had already taken it. She gave Resident D his correct medication and compared the difference in medications between Resident D's medication and Resident B's medication. The finasteride was different, and she gave Resident B the rest of her correct morning medications. It was a really busy day, and she forgot about it. Normally, she would had notified the DON, NP, family and would had checked the resident's vitals. She totally forgot about the error and didn't report it to the oncoming nurse. A current facility policy, updated 9/20, titled "Recording Medication/Treatment Errors,"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANNE - VICTORY NOLL	25 VICTORY NOLL DRIVE HUNTINGTON, IN 46750

(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
	provided by the DON, on 6/15/23 at 10:25 a.m., indicated the following: "...Policy Interpretation and Implementation 1. Once it has been determined a medication error has occurred, the resident's physician and family must be notified and notification must be documented on the Medication Error Report...3. Resident's condition should be observed and documented on the Medication Error Report for 72 hours...." This state residential finding relates to Complaint IN00410414.			