STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155693	A. BUILDING 00 B. WING	12/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SILVER OAKS HEALTH CAMPUS	2011 CHAPA STREET COLUMBUS, IN 47203

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00392018 completed on November 1, 2022. Complaint IN00392018 - Not corrected. Survey date: December 05, 2022. Facility number: 002955 Provider number: 155693 AIM number: 200346570 Census Bed Type: SNF/NF: 10 SNF: 31 NF: 14 Residential: 29 Total: 84 Census Payor Type: Medicare: 31 Medicaid: 14 Other: 10 Total: 55 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 6, 2022.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review.	
F 0641 SS=G Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to prevent medication errors for 3 of 4	F 0641	**F 641 Accuracy of Assessments** It is the practice of this provider to	12/21/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela Cole	Executive Director	12/19/2022

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	residents reviewed for medications errors. This deficient practice resulted in one resident requiring hospitalization. (Residents B, C, and D) Findings include: 1. The clinical record for Resident D was reviewed on 12/05/22 at 11:15 A.M. An Annual MDS (Minimum Data Set) assessment, dated 11/18/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, hypertension, diabetes, anemia, dementia, and depression. A Progress Note, dated 12/04/22 at 9:55 P.M., indicated the nurse went in to give the nighttime medications. The resident was having difficulty with getting the medications down. She went to check the nursing report sheet and she discovered she administered the medications to the wrong resident. The resident listed on the report sheet was in the wrong bed. The NP (Nurse Practitioner) was notified, and a decision was made to send the resident to the local hospital for monitoring of the blood pressure. The DON (Director of Nursing) and family were notified. The Medication Error Event, dated 12/04/22 at 10:03 P.M., indicated the resident was given her roommate's (Resident F) medications. Resident F's physician's orders indicated Resident D had received the following nighttime medications: - atorvastatin (a medication for hyperlipidemia) 10 mg (milligrams), - diltiazem (a medication for hypertension) 180 mg, - gabapentin (a medication for neuropathy) 300 mg,		provide care/services for highest wellbeing in accordance with State and Federal law. **1: What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** · Resident C no longer resides at the campus and suffered no adverse events from incident. MD was notified as to occurrence and resident was monitored in accordance with our “Medication Error” policy and procedure. Staff member identified as responsible for the medication error was provided re-education to our policy and procedure regarding “Medication Errors” and “The Five Rights of Medication Administration”. · Resident B had no adverse events from incident. MD was notified as to occurrence and resident was monitored in accordance with our “Medication Error” policy and procedure. Staff member identified as responsible for the medication error was provided re-education to our policy and procedure regarding “Medication Errors” and “The Five Rights of Medication Administration.” · Resident D’s MD was notified of medication error and orders obtained to send resident	

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	- mesalamine (a medication for colitis) 1600 mg, - metoprolol tartrate (a medication for hypertension) 200 mg, and - clonidine (a medication for hypertension) 0.1 mg. A Hospital Emergency Medicine Note, dated 12/04/22, indicated the resident was being seen in the ER (Emergency Room) after getting the wrong medications. The resident had received clonidine 0.1 mg, diltiazem 180 mg, mesalamine 1600 mg, metoprolol 200 mg, and Lipitor. The resident was in no acute distress and had bradycardia (slow heart rate) upon admission. A Hospital H&P (History and Physical), dated 12/5/22, indicated the resident was seen in the ER after receiving her roommate's medications. Her home medication list did not include any of the given medications. The resident denied any acute complaints. An EKG (Electrocardiography) test was completed in the ER that showed sinus bradycardia. A short stay was expected. 2. The clinical record for Resident B was reviewed on 12/05/22 at 11:20 A.M. A Quarterly MDS assessment, dated 10/01/22, indicated the resident was severely cognitively impaired. The diagnoses included, but were not limited to, heart failure, hypertension, diabetes, and dementia. A Progress Note, dated 11/27/22 at 10:06 P.M., indicated during the evening medication pass it was noted Resident B had the following orders: - gabapentin 600 mg, three times a day at 6:00 A.M. to 10:00 A.M., 1:00 P.M. to 3:00 P.M., and 8:00 P.M. to 10:00 P.M., - gabapentin 600 mg, three times a day at 12:00 A.M., 12:00 P.M., and 6:00 P.M., and - gabapentin 300 mg, once a day at 6:00 P.M.		to the ER for monitoring and possible treatment related to incident regarding medication error. Resident was admitted and returned to facility. Staff member identified as responsible for the medication error was provided re-education to our policy and procedure regarding “Medication Errors” and “The Five Rights of Medication Administration.” **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** · All residents have the potential to be affected by the alleged deficient practice. · All residents with medication errors for the last quarter (3 months) were reviewed to identify root causation for errors along with employees involved in determination for individualized training needs and monitoring. **3: What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · DNS/Designee provided re-education with nursing staff regarding our policy and procedures regarding “The Five Rights of Medication Administration” and our “Medication Error” policy and procedure.	

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	The progress note, dated 11/16/22, indicated an order was found from hospice for gabapentin 600 mg, three times a day. Hospice was called to clarify that the order from 11/16/22 was the correct order. Family was notified There were no adverse side effects from the medication error. The extra gabapentin was discontinued. A Progress Note, dated 11/28/22 at 3:14 P.M., indicated the IDT (Interdisplinary Team) reviewed the medication error event. The resident had the wrong orders in place for gabapentin. The hospice service was notified and new orders were received. The family was notified. A Medication Error Event, dated 11/27/22 at 9:27 P.M., indicated the medication error began on 11/17/22 and ended on 11/27/22. The correct medication order was for gabapentin 600 mg, three times a day. The error was a transcription error. The resident had no adverse side effects. A physician's order, dated 11/17/22 through 11/27/22, indicated the resident was to receive gabapentin 300 mg, once a day at 6:00 P.M. The November 2022 EMAR (Electronic Medication Administration Record) indicated the resident received the medication every day from 11/17/22 through 11/27/22. A physician's order, dated 08/30/22 through 11/27/22, indicated the resident was to receive gabapentin 600 mg, three times a day. The November 2022 EMAR indicated the resident had received the medication, three times a day from 11/01/22 through 11/27/22. A physician's order, dated 11/17/22 through 12/04/22, indicated the resident was to received		**4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place?** · The DNS and/or Designee will be responsible for the completing of Medication Error QA tool weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · In addition to completion of the QA tool, the DHS and/or Designee will perform random medication pass observations with three nursing staff to ensure compliance with our policy regarding the five rights of medication administration weekly times 4 weeks, bi-monthly times 2 months, monthly times 4 and then quarterly to encompass all shifts until continued compliance is maintained for 2 consecutive quarters. · The results of these audits will be reviewed by the CQI committee overseen by the ED. If threshold of 90% is not achieved, an action plan will be developed.	

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	gabapentin 600 mg, three times a day. The November 2022 EMAR indicated the resident had received the medication, three times a day from 11/17/22 through 11/27/22. 3. The clinical record for Resident C was reviewed on 12/05/22 at 11:25 A.M. An Admission MDS assessment, dated 11/08/22, indicated the resident was cognitively intact. The diagnoses included, but were not limited to, fracture to left humerus, hypertension, depression, and restless leg syndrome. A Progress Note, dated 12/02/22 at 1:41 P.M., indicated the NP and resident were notified of a medication error on 12/01/22. No new orders were received. A Medication Error Event, dated 12/02/22, indicated the resident had received the wrong dose of diazepam (an antianxiety medication) on 12/01/22. The resident had an order for diazepam 1 mg, every 8 hours as needed for muscle spasms. The resident had received the roommate's diazepam 2 mg dose on 12/01/22 at 10:00 P.M. There were no adverse side effects noted. During an interview on 12/05/22 at 11:53 A.M., LPN 4 indicated to identify a resident for medication administration she would ask the resident their name, look at their picture in the EMAR, and if there was any doubt of who the resident was, she would ask another staff member to verify the resident's identity. The five rights of medication administration are the following: - Right resident, - Right medication, - Right route, - Right time, and			

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	- Right dose. During an interview on 12/05/22 at 11:52 A.M., the DON indicated since the last citation she had in-serviced staff on medication error documentation, the five rights of medication administration, and resident bathing. There was a big in-service and all staff attended, the in-service form didn't list the five rights, but she did review it with the staff. The staff were in-serviced on 11/16/22. The current facility policy titled "Medication Administration-General Guidelines", revised on 11/18, was provided by the DON on 12/05/22 at 1:08 P.M. The policy indicated, "...Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so...FIVE RIGHTS-Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration : (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. The current facility policy, titled "Guidelines for Medication Error Reporting", with a review date of 10/01/21, was provided by the DON on 12/05/22 at 1:08 P.M. The policy indicated, "...Medication errors will be reviewed by the Quality Assurance Committee to identify trends and/or actions for implementations..." This deficiency was cited on 11/01/2022. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	3.1-48(c)(2) 3.1-37(a)			