STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155368	A. BUILDING _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TODD-DICKEY NURSING AND REHABILITATION	**712 W 2ND ST LEAVENWORTH, IN 47137**

(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 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00424141 Complaint IN00424141 - No deficiencies related to the allegation is cited. An unrelated deficiency is cited Survey dates: January 17 and 18, 2024 Facility number: 000490 Provider number: 155368 AIM number: 100291320 Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 3 Medicaid: 37 Other: 18 Total: 58 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 21, 2024.	F 000		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755		

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
	155368	A. BUILDING _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TODD-DICKEY NURSING AND REHABILITATION	712 W 2ND ST LEAVENWORTH, IN 47137

(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 755	Continued From page 1 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure medication errors did not occur for 1 of 3 residents reviewed for medication administration. (Resident C) Findings include: 1. The clinical record for Resident C was reviewed on 1/17/24 at 1:02 p.m. The diagnoses included, but were not limited to, congestive heart failure, depression, anxiety and hypertension.	F 755	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155368	A. BUILDING _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TODD-DICKEY NURSING AND REHABILITATION	712 W 2ND ST LEAVENWORTH, IN 47137

(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 755	Continued From page 2	F 755		

The incident report, dated 6/10/23 at 1:33 p.m., indicated Resident C had a medication error. The resident was sent to the hospital and diagnosed with a urinary tract infection.

The progress note, dated 6/10/23 at 8:15 a.m., indicated QMA (Qualified Medication Aide) 4 administered the wrong medication to Resident C. The physician was notified with orders to obtain vital signs every 4 hours, check blood sugars every shift, hold the resident's morning medication, and to administer the resident's 12 p.m. medications as ordered.

Review of the medication error report, dated 6/15/23, indicated QMA 4 administered Resident D's morning medications to Resident C which included the following:

- Baclofen (medication for muscle spasms) 20 mg (milligrams)
- Centrum Silver supplement
- Divalproex (medication for convulsions) 1,500 mg
- Metformin (medication for diabetes) 500 mg
- Neurontin (medication used for pain) 400 mg
- Oxcarbazepine (medication used for seizures) 600 mg
- Paxil (antidepressant) 30 mg

The clinical record lacked documentation of a physician's order for the above medications.

The written statement from QMA 4, dated 6/13/23, indicated on 6/10/23, QMA 4 had two residents left to pass medications to, Resident C and Resident D. QMA 4 had both resident's medications ready. Prior to administration, QMA 4 was distracted when her aides asked her some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155368	A. BUILDING _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TODD-DICKEY NURSING AND REHABILITATION	712 W 2ND ST LEAVENWORTH, IN 47137

(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 755	Continued From page 3	F 755		

questions along with a resident. She planned to go to Resident C's room. She grabbed Resident D's cup of medications instead of Resident C's and administered Resident D's medications to Resident C. When she returned to the medication cart, QMA 4 immediately realized the mistake and the physician was notified.

During an interview on 1/17/24 at 1:19 p.m., QMA 4 indicated on the morning of 6/10/23, she only had two residents left to administer medication. She had gotten distracted when a couple of aides approached her during her medication pass. She planned to administer medication to Resident C and then Resident D. She grabbed Resident D's medications rather than Resident C's. She realized what she had done right after that. She reported to the charge nurse, DON, family and physician and followed the orders provided by the physician. On 1/18/24 at 10:49 a.m., QMA 4 indicated the 5 rights of medication administration were right person, right medication, right time, right dose and right route.

On 1/18/24 at 9:40 a.m., the Executive Director provided a current copy of the document titled "Medication Errors" dated 11/02. It included, but was not limited to, "Policy...It is the policy of this provider to ensure residents residing in the facility are free of medication errors..."

On 1/18/24 at 9:40 a.m., the Executive Director provided a current copy of the document titled "Medication Administration" dated 2/2010. It included, but was not limited to, "Procedure Steps...Medications are prepared for one resident at a time...Perform the 5 rights of medication...Right Resident...."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155368	A. BUILDING _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TODD-DICKEY NURSING AND REHABILITATION	712 W 2ND ST LEAVENWORTH, IN 47137

(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 755	Continued From page 4	F 755		

2. The clinical record for Resident D was reviewed on 1/18/24 at 9:51 a.m. The diagnoses included, but were not limited to, cerebral palsy, convulsions, diabetes and depression.

Review of the June 2023 medication administration record indicated the resident had the following morning medications ordered:

- Baclofen 20 mg at 8:00 a.m.
- Centrum Silver, one tablet between 7:00 a.m. and 11:00 a.m.
- Divalproex 1,500 mg between 7:00 a.m. and 11:00 a.m.
- Metformin 500 mg between 7:00 a.m. and 11:00 a.m.
- Neurontin 400 mg at 8:00 a.m.
- Oxcarbazepine 600 mg between 7:00 a.m. and 11:00 a.m.
- Paxil 30 mg between 7:00 a.m. and 11:00 a.m.

The Past noncompliance began on 6/10/23. The deficient practice was corrected by 6/15/23 after the facility implemented a systemic plan that included the following actions: All staff were educated on Medication pass policy/procedure which included the preparation of medications for one resident at a time and performing the 5 rights of medication administration of right person (6/15/23); one on one teaching and a medication pass observation completed with QMA 4. (6/15/23)

3.1-48(c)(2)