PRINTED:	05/20/2016
FORM AP	PROVED
OMB NO. ()938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/21/2016
	PROVIDER OR SUPPLIEI		10312	ADDRESS, CITY, STATE, ZIP CODE ALLISONVILLE RD RS, IN 46038	-
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE (X5) COMPLETION DATE
Bldg. 00	Complaints IN0 and IN00198324 Complaint IN00 No deficiencies are cited. Complaint IN00 Unsubstantiated evidence. Complaint IN00 Federal/State de F333.	193434 - Substantiated. related to the allegation 193771 - due to lack of sufficient 198324 - Substantiated. ficiencies are cited at pril 20 and 21, 2016 :: 012466 r: 155786 01014060	F 0000	The creation and submission of the plan of correction doesnot constitute an admission by this provider or any conclusion set fort in thestatement of deficiencies, or any violation of regulation. This provider respectfully requests that the2567 Plan of Correction be considered the letter of credible allegation and request a desk revie forpaper compliance in lieu of a po survey visit on or after May 11, 2016.	h of w

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE C A. BUILDING B. WING	A. BUILDING 00 COMPLET B. WING 04/21/20			
	PROVIDER OR SUPPLIE		10312	ALLISONVILLE RD RS, IN 46038			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
	cited in accorda 16.2-3.1.	ies reflect State findings nce with 410 IAC completed by 30576 on					
⁻ 0333 SS=G Bldg. 00	ERRORS The facility must of free of any signifi Based on intervent the facility faile received the corr Methadone (lique which resulted in (medication used a narcotic overed reviewed for medication (Resident #C) Findings include The clinical recorrection reviewed on 4/2	uid pain medication) n the use of Narcan d to reverse the effects of lose) for 1 of 4 residents edication administration. e: ord for Resident #C was 10/16 at 11:45 a.m. ded, but was not limited	F 0333	F 333 The facility respectfully requests a face-to-face IDR for F333 as the facility disagrees w the scope and severity of the deficiency. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident #C no longer reside in this facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken ·Allresidents have the potential to be affected by the deficient practice and are identified by	s ?		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION (2)	X3) DATE SURVEY COMPLETED
		155786	B. WING		04/21/2016
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
ALLISON	NVILLE MEADOWS	>	FISHE	RS, IN 46038	<u>.</u>
X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
	fibrillation.			those residents who take liquid narcotics.	
				·All Licensed Nurses were	
	The April 2016			in-serviced on 4/17/16 and will	be
	Administration	Record included, but was		in-serviced again regarding	
	not limited to, t	he following:		medication administration	
	"OrderMeth	adone Intensol		practices including five rights of	f
		oncentrate; 10 mg		medication administration, and administration of liquid	
	[milligrams]/ml			medications by oral syringes by	1
		ount to Administer: 10 mg		the Clinical Education	
	-	alFrequencyEvery 12		Coordinator (CEC)/designee by	,
				5/11/16.	
	HoursSchedu			·All Licensed Nurses will have	
		6Scheduled Time9:00		Medication pass observation, a	nd
		Date - Time4/10/2016		skills validation completed by	
	11:44 AMRea	asons/CommentLate		5/11/16 by the CEC/designee. •DNS will complete audit of al	1
	Administration:	Administered		residents to identify residents	
	lateComment	: backed up"		taking liquid narcotic medication	ns
				and review for medication	
	The narcotic co	unt sheet, dated 3/29/16,		error/discrepancies by 5/11/16.	
		as not limited to, the		What measures will be put	
		me of pharmacy]		into place or what systemic	
	0.5	name]Methadone 10		changes you will make to ensure that the deficient	
	mg[milligrams]	-		practice does not recur?	
				·All Licensed Nurses were	
		e 1ml [milliliter] (10 mg)		in-serviced on 4/17/16 and will	be
		sublingually [underneath		in-serviced again regarding	
	• •	ry 12 hoursDate4/9		medication administration	
		9P [9:00 p.m.]Amt		practices including five rights of	
		1ml [milliliter]Qty		medication administration, and administration of liquid	
	[quantity] Rema	ain9 [9		medications by oral syringes by	,
	milliliters]Dat	te4/10		the Clinical Education	
	[4/10/16]Time	e[9A with a line through		Coordinator (CEC)/designee by	, I
		m.]Amt [amount]		5/11/16.	
		[quantity] Remain0		·All Licensed Nurses will have	
		d Nurse] #1's name]"		Medication pass observation, a	nd
		π manufactor π is name j		skills validation completed by 5/11/16 by the CEC/designee.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

WH6N11 Facility ID: 012466

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVI COMPLETED 04/21/2016	
	PROVIDER OR SUPPLIE		10312	ADDRESS, CITY, STATE, ZIP CODE ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OF The Event Report a.m., included, 1	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) ort dated 4/11/16 at 9:43 put was not limited to, the	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY) •All liquid narcotic medica will have an additional warr label placed on the medicat	DRIATE COM Itions hing	(X5) IPLETIO DATE
	09:42AMDest unresponsiveI (Situation, Back Recommendation Communication responding to st commandsSki Id (extremities) feetProblem bedside clinicia was cyanotic [a purple coloration apnea [cessation hands and feet of responsive to an seems to beCardiacN Mental status ch undetermined to get worse, be	a ToolBackgroundNot imuliUnable to follow nPaleExtremitiesCo - hands and Based on assessment, the n concludes: Resident ppearance of a blue or n of the skin] with bits of n of breathing], residents cold. Resident not by stimuliThe problem eurologicRespiratory hangeProblem Resident unstable, likely dside clinician requests -		alert the nurse to dosage st by the DNS/designee by 5/ ·Licensed nurses will be educated on liquid narcotic medications, location and placement of alert labels up delivery of medications, and where alert labels will be and on each medication cart by 5/11/16 by the CEC/design ·TheDNS/Designee will re narcotic count sheets daily narcotic administration, medication errors, and any dosage discrepancies. The medication error policy/prot will be followed by DNS/desi for any medication errors and dosage discrepancy found. · Liquid narcotic medication be audited daily by the DNS/designee to ensure th there is a dropper supplied manufacturer or the smaller syringe is available labeled that medication, and to ensure	rrength 11/16. 2000 d vailable ee. eview for ocol signee nd/or on will at by the st oral for ure	
	p.m., recorded a at 10:34 a.m., ir "Found resident with bouts of ap to touch. Reside any stimuli. VS normal range. C	d" , dated 4/10/16 at 3:00 as a late entry on 4/11/16 included the following: unresponsive, cyanotic onea. Hands and feet cold ent would not respond to [vital signs] out of contacted the DON rsing] (DON's first		dosage that strength and hi alert stickers are present ar intact. How the corrective action will be monitored to ensur deficient practice will not i.e., what quality assurance program will be put into p ·Medication Error CQI will completed weeklyX 4 week monthly X 6 months, and the quarterly for one year with reported to the Continuous	n(s) re the recur, e lace? I be s, s,	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X2) MULTIPLE CONSTRUCTION X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155786 B. WING 04/21/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10312 ALLISONVILLE RD ALLISONVILLE MEADOWS FISHERS. IN 46038 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG Quality Improvement Committee name), and [sic] Hospice. Hospice overseen by the Executive contacted MD [medical doctor]. Family Director. (first name of Resident #C's son) notified. · If a threshold of 95% is not Hospice felt it would benefit resident to achieved, an action plan will be be sent out for eval [evaluation] and tx developed to ensure compliance. [treatment]. Resident transferred [sic] out at 9:30 pm to [name of hospital]." The physician order, dated 4/10/16 at 4:30 p.m., indicated the following: "Narcan 0.4 mg [milligrams]/ml [per 1 milliliter]...IM [intramuscularly] now " The nurses note, dated 4/10/16 at 5:00 p.m., recorded as a late entry on 4/11/16 at 10:49 a.m., included the following: "Narcan was administered to Resident around 4:30 pm. Resident vomited large amounts of undigested food about 5:00 pm. DON, writer, hospice present..." The document titled, "RESIDENT EVENT INVESTIGATION QUESTIONNAIRE", included, but was not limited to, the following: "[Resident #C's name]...Date of Event...3:01 p [p.m.]...How often do you care for this resident...[RN #1's name] x [times] [division sign] [1]...Did anything occur that may have been construed by he resident...Med [medication] Error...Do you have ay idea of how this injury...may have occurred...Med Error...In your own words, tell me or write down exactly Facility ID: 012466 If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

NAME OF PROVIDER OR SLEPTLER STREET ADDRESS, CITY, STATE, ED CODE ALLISONVILLE MEADOWS 103/12 ALLISONVILLE RD PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID REGULTATORY OR LSCIDINTERING INFORMATION) ID ID Mappened [sic] with this resident to the best of your knowledge4/10/16 at 3pm IS:00 p.m.] [LEN [Licensed Practical IN Nurse] #35 name] and [RN #1's name] were counting Narcotics and an error was made on resident [Resident #C's first name]. Im Im Imiliar at 9A (9:00 a.m.]/9 pm [9:00 p.m.]. Imiliar at 9A (9:00 a.m.]/9 pm [9:00 p.m.][sic] resident was given 9 ml Imiliar at 9A (9:00 a.m.]/9 pm [9:00 p.m.] Imiliar at 9A (9:00 a.m.]/9 pm [9:00 p.m.]. Imiliar at 9A (9:00 a.m.]/9 pm [9:00 p.m.]. Imiliar at 9A (9:00 a.m.]/9 pm [9:00 p.m.][sic] resident was given 9 ml Imiliar at 9A (9:00 a.m.]/9 pm [9:00 p.m.]. Imiliar at 9A (9:00 a.m.]/9 pm [9:01 p.m.] Imiliar at 9A (9:00 a.m.]/9 pm [9:02 p.m.][sic] resident was given 9 ml Imiliar at 9A (9:00 a.m.]/9 pm [9:02 p.m.] Imiliar at 9A (9:00 a.m.]/9 pm [9:01 p.m.] Imiliar at 9A (9:00 a.m.]/9 pm [9:02 p.m.] Imiliar at 9A (9:00 p.m.]. Imiliar at 9A (9:00 a.m.]/9 pm [9:01 p.m.] Imiliar at 9A (9:00 p.m.] Imiliar at 9A (9:00 p.m.] Imiliar at 9A (9:00 a.m.]/9 pm [9:01 p.m.] Imiliar at 9A (9:00 p.m.] Imiliar at 9A (9:00 p.m.] Imiliar at 9A (9:00 a.m.]/9 pm [9:02 p.m.] Imiliar at 9A (9:00 p.m.] <t< th=""><th>AND PLAN</th><th>OF CORRECTION</th><th>IDENTIFICATION NUMBER: 155786</th><th>(X2) MULTIPLE CO A. BUILDING B. WING</th><th>COMPLETED 04/21/2016</th></t<>	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CO A. BUILDING B. WING	COMPLETED 04/21/2016	
PBEFIX TAG (PACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (PACH DEFICIENCY MUST BE PRECIDED BY FULL TAG COMMENTIC (PRESS REFERCED TO THE APPROPRIATE DESS REFERENCE TO THE APPROPRIATE DATE MILE TO DEST DESS REFERENCE TO THE APPROPRIATE DATE DATE MILE TO DEST DESS REFERENCE TO THE APPROPRIATE DATE DATE MILE TO DEST DESS REFERENCE TO THE APPROPRIATE DATE DATE MILE TO DEST DEST DEST DESS REFERENCE TO THE APPROPRIATE DATE DATE MILE TO DEST DEST DEST DESS REFERENCE TO THE APPROPRIATE DATE DEST DEST DESS DEST DEST DESS DE DATE MILE TO DEST DESS REFERENCE DATE DATE DEST DESS DEST DESS DEST DESS DESS DESS				10312	ALLISONVILLE RD	DE
happened [sic] with this resident to the best of your knowledge4/10/16 at 3pm [3:00 p.m.] [LPN [Licensed Practical Nurse] #3's name] and [RN #1's name] were counting Narcotics and an error was made on resident [Resident #C's first name] - Resident's order was to give Methadone 10 mg [milligrams]/ml [per 1 milliliter] at 9A [9:00 a.m.]/9 pm [9:00 p.m.][sic] resident was given 9 ml [milliliters] at 1 pm [1:00 p.m.] Was first aid administeredNarcan 0.4 mg [milliligrams]/ml [per 1 milliliter] IM [intramuscular/y] nowSummary of investigation9 ml [milliliters[sic] methadone given at approximately [sic] 1 pm [1:00 p.m.] or 4/10/16 [curvy line] med [medication] error noted - 4/10/16 at 4pm [4:00 p.m.] resident was unresponsive, MD [medical doctor] [sic] hospice, DNS [Director of Nursing] et [and] family calleN.O. [new order] narcan [sic] 0.4 mg [milligram]/ml [per 1 milliliter] given in [L. with circle around it] [left] hip - At 5 pm [5:00 p.m.] resident vomitted [sic] a large amt [amount] of yellow undigested foodSignature of Investigator[DON's	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD BE COMPLETIO
		best of your kno [3:00 p.m.] [LP Nurse] #3's nam were counting N made on residen name] - Residen Methadone 10 n milliliter] at 9A p.m.][sic] reside [milliliters] at 1 first aid adminis [milligrams]/ml [intramuscular]; investigation9 methadone give pm [1:00 p.m.] med [medicatio 4pm [4:00 p.m. unresponsive, N hospice, DNS [[and] family ca narcan [sic] 0.4 milliliter] given it] [left] hip - A resident vomitte [amount] of yel foodSignature signature]"	owledge4/10/16 at 3pm N [Licensed Practical ne] and [RN #1's name] Narcotics and an error was nt [Resident #C's first nt's order was to give mg [milligrams]/ml [per 1 [9:00 a.m.]/9 pm [9:00 ent was given 9 ml pm [1:00 p.m.]Was steredNarcan 0.4 mg [per 1 milliliter] IM y] nowSummary of 0 ml [milliliters[sic] en at approximatley [sic] 1 on 4/10/16 [curvy line] n] error noted - 4/10/16 at] resident was AD [medical doctor] [sic] Director of Nursing] et lledN.O. [new order] mg [milligram]/ml [per 1 in [L with circle around t 5 pm [5:00 p.m.] ed [sic] a large amt low undigested e of Investigator[DON's			
company][Resident #C's		following: "[na	me of hospice			

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155786	A. BUILDING <u>00</u> COMPL B. WING 04/21/		ATE SURVEY MPLETED /21/2016		
	PROVIDER OR SUPPLI			10312	ADDRESS, CITY, STATE, ZIP CODE ALLISONVILLE RD RS, IN 46038		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
	name]Medica discovered pati medication @ [and] was gasp [4:25 p.m.], [si 0.4 mg [milligr per office of [n StatusLetharg mitingat 1650 p.m.]Respira musclesPain. over it] with ea mg [milligrams 10 mg) at 1300 dose from AM staff recognized p.m]. Phoned [hospice before The hospital do Record", dated included, but w following: "8 admitted to inp hospiceTrans [Extended Cara close monitorin Patient has not medications sin 4/10/2016Mi	ations ChangesStaff ent received too much [at] 1300 [1:00 p.m.] et ing for breath at 1625 c] received [sic]Narcan ams] at 1630 [4:30 p.m.] ame of physician]Mental gicGastrointestinalVo 0 [4:50 toryusing accessory moaning [c with line ch breathReceived 90 s] Methadone (instead of [1:00 p.m.], scheduled 0900 [9:00 a.m.]other d problem at 1500 [3:00 physician name] staff and 1600 [4:00 p.m.]"					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OT A TEMP						OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155786	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 04/21/2016	
	PROVIDER OR SUPPLIEI		10312	ADDRESS, CITY, STATE, ZIP COI ALLISONVILLE RD RS, IN 46038	DE	
XLLISU (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF called her and to gotten too much indicated, when Methadone was RN #1 told her s the bottle, 9 ml (indicated when s was empty. The told her she did saw the 10 and t DON indicated s milliliter of Nard intramuscularly Resident #C vor around 5:00 p.m. During an intervy p.m., the DON i policy/procedure overdoses.	TATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL RESCIDENTIFYING INFORMATION) old her someone had in medication. The DON asked how much given to Resident #C, she gave what was left in (milliliters). The DON she looked at the bottle, it DON indicated RN #1 not have her glasses and that is what she gave. The she administered 1 can, per physicians order, around 4:30 p.m. and mited undigested food	ID PREFIX TAG	CS, IN 40038	ULD BE	(X5) COMPLETION DATE

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