STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00193434, IN00193771, and IN00198324. Complaint IN00193434 - Substantiated. No deficiencies related to the allegation are cited. Complaint IN00193771 - Unsubstantiated due to lack of sufficient evidence. Complaint IN00198324 - Substantiated. Federal/State deficiencies are cited at F333. Survey dates: April 20 and 21, 2016 Facility number: 012466 Provider number: 155786 AIM number: 201014060 Census bed type: SNF: 19 SNF/NF: 111 Total: 130 Census payor type: Medicare: 19 Medicaid: 85 Other: 26	F 0000	The creation and submission of the plan of correction doesnot constitute an admission by this provider or any conclusion set forth in thestatement of deficiencies, or of any violation of regulation. This provider respectfully requests that the2567 Plan of Correction be considered the letter of credible allegation and request a desk review forpaper compliance in lieu of a post survey visit on or after May 11, 2016.	

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

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	Total: 130 Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on April 27, 2016			
F 0333 SS=G Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a resident received the correct amount of Methadone (liquid pain medication) which resulted in the use of Narcan (medication used to reverse the effects of a narcotic overdose) for 1 of 4 residents reviewed for medication administration. (Resident #C) Findings include: The clinical record for Resident #C was reviewed on 4/20/16 at 11:45 a.m. Diagnoses included, but was not limited to, dementia, anxiety and atrial	F 0333	**F 333** The facility respectfully requests a face-to-face IDR for F333 as the facility disagrees with 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 resides 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	05/11/2016

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	fibrillation. The April 2016 Medication Administration Record included, but was not limited to, the following: "...Order...Methadone Intensol (methadone)...concentrate; 10 mg [milligrams]/ml [per 1 milliliter]...Amount to Administer: 10 mg [milligrams]; oral...Frequency...Every 12 Hours...Scheduled Date...4/10/2016...Scheduled Time...9:00 AM...Charted Date - Time...4/10/2016 11:44 AM...Reasons/Comment...Late Administration: Administered late...Comment: backed up...." The narcotic count sheet, dated 3/29/16, included, but was not limited to, the following: "[name of pharmacy]... [Resident #C's name]...Methadone 10 mg[milligrams]/ml [per 1 milliliter]...Give 1ml [milliliter] (10 mg) [10 milligrams] sublingually [underneath the tongue] every 12 hours...Date...4/9 [4/9/16]...Time...9P [9:00 p.m.]...Amt [amount] Given...1ml [milliliter]...Qty [quantity] Remain..9 [9 milliliters]...Date...4/10 [4/10/16]...Time...[9A with a line through it] 1pm [1:00 p.m.]...Amt [amount] Given...10...Qty [quantity] Remain...0... [RN [Registered Nurse] #1's name]...."		those residents who take liquid narcotics. ·All Licensed Nurses were in-serviced on 4/17/16 and will be in-serviced again regarding medication administration practices including five rights of medication administration,and administration of liquid medications by oral syringes by the Clinical Education Coordinator (CEC)/designee by 5/11/16. ·All Licensed Nurses will have Medication pass observation, and skills validation completed by 5/11/16 by the CEC/designee. ·DNS will complete audit of all residents to identify residents taking liquid narcotic medications and review for medication error/discrepancies by 5/11/16. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·All Licensed Nurses were in-serviced on 4/17/16 and will be in-serviced again regarding medication administration practices including five rights of medication administration, and administration of liquid medications by oral syringes by the Clinical Education Coordinator (CEC)/designee by 5/11/16. ·All Licensed Nurses will have Medication pass observation, and skills validation completed by 5/11/16 by the CEC/designee.	

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	The Event Report dated 4/11/16 at 9:43 a.m., included, but was not limited to, the following: "...Event Date: 04/10/2016 09:42AM...Description...Resident found unresponsive...Event Details...SBAR (Situation, Background, Assessment, Recommendations) Physician Communication Tool...Background...Not responding to stimuli...Unable to follow commands...Skin...Pale...Extremities...Cold (extremities) - hands and feet...Problem...Based on assessment, the bedside clinician concludes: Resident was cyanotic [appearance of a blue or purple coloration of the skin] with bits of apnea [cessation of breathing], residents hands and feet cold. Resident not responsive to any stimuli...The problem seems to be...Cardiac...Neurologic...Respiratory.. Mental status change...Problem undetermined...Resident unstable, likely to get worse, bedside clinician requests - Hospice notified...." The nurses note, dated 4/10/16 at 3:00 p.m., recorded as a late entry on 4/11/16 at 10:34 a.m., included the following: "Found resident unresponsive, cyanotic with bouts of apnea. Hands and feet cold to touch. Resident would not respond to any stimuli. VS [vital signs] out of normal range. Contacted the DON [Director of Nursing] (DON's first		·All liquid narcotic medications will have an additional warning label placed on the medication to alert the nurse to dosage strength by the DNS/designee by 5/11/16. ·Licensed nurses will be educated on liquid narcotic medications, location and placement of alert labels upon delivery of medications, and where alert labels will be available on each medication cart by 5/11/16 by the CEC/designee. ·TheDNS/Designee will review narcotic count sheets daily for narcotic administration, medication errors,and any dosage discrepancies. The medication error policy/protocol will be followed by DNS/designee for any medication errors and/or dosage discrepancy found. · Liquid narcotic medication will be audited daily by the DNS/designee to ensure that there is a dropper supplied by the manufacturer or the smallest oral syringe is available labeled for that medication, and to ensure dosage that strength and high alert stickers are present and intact. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** ·Medication Error CQI will be completed weeklyX 4 weeks, monthly X 6 months, and then quarterly for one year with results reported to the Continuous	

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	name),and [sic] Hospice. Hospice contacted MD [medical doctor]. Family (first name of Resident #C's son) notified. Hospice felt it would benefit resident to be sent out for eval [evaluation] and tx [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		Quality Improvement Committee overseen by theExecutive Director. · If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	happened [sic] with this resident to the best of your knowledge...4/10/16 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 administered...Narcan 0.4 mg [milligrams]/ml [per 1 milliliter] IM [intramuscularly] now...Summary of investigation...9 ml [milliliters[sic] methadone given at approximatley [sic] 1 pm [1:00 p.m.] on 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 called...N.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 food...Signature of Investigator...[DON's signature]...." The Hospice note, dated 4/10/16 at 4:45 p.m., included, but was not limited to, the following: "[name of hospice company]...[Resident #C's			

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	name]...Medications Changes...Staff discovered patient received too much medication @ [at] 1300 [1:00 p.m.] et [and] was gasping for breath at 1625 [4:25 p.m.], [sic] received [sic]Narcan 0.4 mg [milligrams] at 1630 [4:30 p.m.] per office of [name of physician]...Mental Status...Lethargic...Gastrointestinal...Vomiting...at 1650 [4:50 p.m.]...Respiratory...using accessory muscles...Pain...moaning [c with line over it] with each breath...Received 90 mg [milligrams] Methadone (instead of 10 mg) at 1300 [1:00 p.m.], scheduled dose from AM 0900 [9:00 a.m.]...other staff recognized problem at 1500 [3:00 p.m]. Phoned [physician name] staff and hospice before 1600 [4:00 p.m.]...." The hospital document titled, "Inpatient Record", dated 4/11/2016 at 9:27 a.m., included, but was not limited to, the following: "...85 yo [year old] female admitted to inpatient hospice...Transferred from ECF [Extended Care Facility] yesterday for close monitoring after receiving Narcan. Patient has not received any opioid medications since 1300 [1:00 p.m.] on 4/10/2016...Minimally responsive...." During an interview on 4/20/16 at 3:10 p.m., the Director of Nursing indicated, on 4/10/16 around 4:00 p.m., LPN #1			

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	called her and told her someone had gotten too much medication. The DON indicated, when asked how much Methadone was given to Resident #C, RN #1 told her she gave what was left in the bottle, 9 ml (milliliters). The DON indicated when she looked at the bottle, it was empty. The DON indicated RN #1 told her she did not have her glasses and saw the 10 and that is what she gave. The DON indicated she administered 1 milliliter of Narcan, per physicians order, intramuscularly around 4:30 p.m. and Resident #C vomited undigested food around 5:00 p.m. During an interview on 4/20/16 at 4:10 p.m., the DON indicated there was not a policy/procedure regarding narcotic overdoses. This Federal tag relates to Complaint IN00198324 3.1-25(b)(9) 3.1-48(c)(2)			