STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 00 B. WING	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALBANY HEALTH CARE & REHABILITATION CENTER	910 W WALNUT ST ALBANY, IN 47320

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00415086. Complaint IN00415086 - Federal/state deficiency related to the allegations is cited at F0760. Survey date: August 16, 2023 Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 79 Total: 79 Census Payor Type: Medicare: 7 Medicaid: 68 Other: 4 Total: 79 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 21, 2023.	F 0000		
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review, the facility failed to prevent a significant medication error when QMA1 administered the wrong medications to Resident B and Resident C. This deficient practice resulted in Resident B being sent to the	F 0760	F760 Med Error 1. What corrective action(s) will be accomplished for those residents	09/04/2023

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

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	hospital where she was diagnosed with accidental drug ingestion and received treatment for lack of adequate oxygen to the body tissues (acute hypoxia), low blood pressure (hypotension), and slow heart rate (bradycardia). Findings include: Review of a 8/14/23 facility-reported incident to the Indiana Department of Health indicated Residents B and C had been administered each other's medications on 8/12/23. Resident B required transfer to the hospital for treatment. The clinical record for Resident B was reviewed on 8/16/2023 at 10:00 a.m. Diagnoses included, hypertension, presence of cardiac pacemaker, cognitive communication deficit, chronic obstructive pulmonary disease, and dementia. The resident was allergic to morphine. The resident's photograph had not been added to the electronic health record. Review of admission Minimum Data Set (MDS) assessment, dated 8/15/2023, indicated the resident had severe cognitive impairment. Resident B had current physician's orders for sertraline HCL(antidepressant) oral concentrated 20 mg/ml. Give one (1) ml by mouth in the morning for depression/anxiety. These medications, intended for Resident B, were administered to Resident C. The clinical record for Resident C was reviewed on 8/16/2023 at 10:47 a.m. Diagnoses included atrial fibrillation, congestive heart failure, hypertension, chronic kidney disease stage 4, and		found to have been affected by the deficient practice? - 1:1 education with QMA 1 regarding medication administration and the “Rights” of medication administration. Skills competency for QMA 1 was completed prior to administration of medications on following morning. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. - 60 day lookback order review indicated no other medication errors in facility. 3. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? -100% education for all nurses and QMAs completed to ensure knowledge of the “rights” to medication administration. Medication administration competency was completed with 100% of nurses and QMAs. All resident identifiers (previously bed 1 and 2) were changed on the physical door as well as in Point	

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	bradycardia. The resident's photograph had not been added to the electronic health record. Review of admission Minimum Data Set (MDS) assessment, dated 8/15/2023, indicated the resident had severe cognitive impairment. Review of the resident's physician orders indicated Resident C had the following current morning medication orders: a. Furosemide (loop diuretic) oral tablet 20 mg. Give 1 tablet by mouth on time a day for diuretic. b. Isosorbide Monoitrate (nitrate) ER tablet extended release 24 hour 30 mg. Give 1 tablet by mouth one time a day for chest pain. c. Lisinopril (anti-hypertensive) oral table 5 mg. Give 1 tablet by mouth one time a day for hypertension. d. Risperdal (anti-anxiety) oral tablet 0.25 mg. Give 1 tablet by mouth one time a day for anxiety. e. Spironolactone (potassium sparring diuretic) oral tablet 25 mg. Give 1 tablet by mouth one time a day for diuretic for congestive heart failure. f. Doxycycline Hyclate (antibiotic) oral tablet 100 mg. Give 1 tablet by mouth two times a day for pneumonia for 10 days. g. Metoprolol Tartrate (anti-hypertensive) oral tablet 25 mg. Give 0.5 tablet by mouth two times a day for hypertension. h. Morphine Sulfate ER (opioid analgesic) oral tablet extended release 15 mg. Give 1 tablet by mouth every 12 hours for pain.. j. Hydroxyzine Pamoate (antihistamine) oral capsule 25 mg. Give 1 capsule by mouth every 8 hours for anxiety and itching. These medications, intended for Resident C, were administered to Resident B.		Click Care to identify as “D for door” and “W for window” to identify physical location. 4. How the corrective action(s) will be monitored to ensure deficient practice will not recure, i.e., what QA program will be put into place. - DON/designee ensure all new nursing staff are aware of the “rights” of medication administration prior to administering medications. Random medication administration competencies will be completed on random shifts and days, 3 times weekly for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, for a minimum of 6 months. The audits will be presented to QA committee review and will continue quarterly until deemed to be in full compliance by QA. 5. By what date will the systemic changes be put into place? September 4th, 2023	

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	Review of a "Change in Condition" note, dated 8/12/2023 at 2:00 p.m., indicated Resident B was sitting up in a chair. The resident was found non-responsive with respirations at six breaths per minute. The resident's oxygen saturation was 92%, and dropped to 84%. Oxygen was applied and titrated to 4 liters, and brought the oxygen saturation to 90%. Narcan was administered and the resident's respirations increased to 10 breaths per minute. The resident became more responsive, but was confused and lethargic. The resident was sent to the hospital for evaluation and treatment. During an interview on 8/16/2023 at 10:06 a.m., the Director of Nursing indicated during the morning medication pass on 8/12/2023, QMA1 entered Resident B and Resident C's room. The two residents were admitted on the same day and were placed in the same room. The residents were new admits and QMA1 was not familiar with them. The QMA asked Resident B if they were [name] and the resident responded "yes". QMA1 prepared the medication and administered it to the resident. Then QMA1 repeated the steps for Resident C. QMA1 returned to the room shortly after administering the medications and a family member was present and called Resident B by the correct name. QMA1 asked the family member to clarify who Resident B and Resident C were. The family member identified the residents correctly. QMA1 realized she had administered the wrong medications to the wrong resident and informed the nurse. Due to having an allergy to morphine, and having been administered morphine, Resident B was assessed and monitored closely. The physician and families were notified. At around 2:00 p.m., Resident B became difficult to arouse. The NP was called and an order for Narcan (opioid			

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	antagonist)) was received. The Narcan was administered and the resident was sent to the hospital for evaluation and treatment. During an interview on 8/16/2023 at 10:33 a.m., QMA1 indicated on 8/12/2023, during the morning medication pass, she entered the room of Resident B and Resident C. QMA1 indicated that was the first time she had seen the two new residents. The QMA asked Resident B if she was (says name) and the resident answered "yes". The QMA administered the medications. The QMA returned to the room later to get a blood pressure for Resident B and a family member was present. The QMA heard the family member call Resident B's correct name and immediately realized she had administered the wrong medications to Resident B and Resident C. The medication error was reported to the nurse. Review of the "Medication Skill Competency: Oral Medication Pass Procedure", dated 3/2015 and last revised 4/20, was provided by the DON on 8/16/2023 at 11:13 a.m. This procedure was to re-educate nursing staff and indicated the following: "...Procedure Steps ...Demonstrates appropriate identification of residents by name, birthdate, photo on chart. Proper use of 5 rights of medication administration demonstrated...." This Federal tag relates to complaint IN00415086. 3.1-48(c)(2)			