

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/21/2023
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NAME OF PROVIDER OR SUPPLIER ROSEWALK AT LUTHERWOODS	STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N RITTER AVE INDIANAPOLIS, IN 46219
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R 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00417592.</p> <p>Complaint IN00417592 - State deficiencies related to the allegations are cited at R0240.</p> <p>Survey date: September 21, 2023</p> <p>Facility number: 011587</p> <p>Residential Census:76</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed on September 25, 2023</p>	R 0000		
R 0240 Bldg. 00	<p>410 IAC 16.2-5-4(d) Health Services - Deficiency</p> <p>Based on interview and record review, the facility failed to ensure medications were administered to the correct residents for 3 of 4 residents reviewed for medication errors (Residents B, C and E) and ensure a resident who required assistance with activities of daily living (ADL) for bathing received that service for 1 of 3 residents reviewed for ADLs (Resident B).</p> <p>Findings include:</p> <p>1. a. The clinical record for Resident B was reviewed on 9/21/23 at 11:26 a.m. Resident B's diagnoses included, but not limited to, diabetes type II and epilepsy (seizures).</p> <p>A physician's order dated 8/28/23 indicated, to</p>	R 0240	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident B has had no adverse effects from medication error. Resident C has had no adverse effects from medication error. Resident E has had no adverse effects from medication error. Resident B has had no adverse effects from not following the service plan as documented for ADL care and shower schedule per Resident B's preference reviewed and in place. QMA 4 received education, counseling,</p>	10/12/2023

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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	<p>send Resident B to the hospital emergency room for evaluation and treatment for a medication error.</p> <p>A nursing note dated 8/28/23 at 8:32 a.m. indicated, a QMA (Qualified Medication Assistant) reported Resident B was given the wrong medications. Resident B was assessed; the on call provider, poison control, resident's daughter and DON (Director of Nursing) were notified; and a new order to send the resident to the emergency room was received.</p> <p>On 9/21/23 at 11:02 a.m. the DON provided a Medication/Treatment Error Report dated 8/28/23. It indicated, QMA 4 had given Resident B another resident's medications and was sent to the emergency room for further evaluation and treatment.</p> <p>An interview with QMA 4 conducted on 9/21/23 at 11:22 a.m. indicated, she had prepped all of her residents' morning medications and placed them in order of their rooms except for one resident's medications as they liked their medications first thing in the morning. However, on that day, Resident B came to her first requesting his morning medications and she "accidentally picked up" the wrong cup of medications and gave them to Resident B. QMA 4 indicated, she realized her error when the resident who usually came for his medications first thing in the morning came to her requesting his morning medications and his cup of medications was missing and Resident B's cup of medications was still there. QMA 4 immediately reported the medication error to the nurse.</p> <p>A list of medications Resident B had received that morning in error on 8/28/23 was provided by DON</p>		<p>and medication pass review and skills validations 9/25/2023. QMA 5 received education, counseling, and medication pass review and skills validations 9/24/2023.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected. No resident was adversely affected. ADL servers per resident service plans, including but not limited to showers, were reviewed with third party/home health provider to ensure no other residents had missed showers or other ADL care. ADL education provided to all qualified staff on 10/2/2023. Medication pass reeducation completed with all qualified staff on 9/29/2023. QMA 4 received education, counseling, and medication pass review and skills validations 9/25/2023. QMA 5 received education, counseling, and medication pass review and skills validations 9/24/2023.</p> <p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur: All residents have the potential to be affected. No resident was adversely affected. Staff qualified to administer medications reeducated by 10/12/23. Staff</p>	

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	<p>on 9/21/23. It indicated, Resident B received, in error, the following medications and doses: Atorvastatin 20 mg(milligrams), a cholesterol reducing medication Baclofen 10 mg, a pain reducing medication Carbidopa 50-200 mg, a Parkinson's medication Clonazepam 2mg, a anti anxiety medication Hydroxyzine 25 mg, an antihistamine Linzess 72 mcg(micrograms), an irritable bowel medication Omeprazole 40 mg, an antiheartburn medication Pregabalin 75 mg, a nerve pain medication Quetiapine fumarate 50 mg, an antipsychotic medication</p> <p>b. The clinical record for Resident C was reviewed on 9/20/23 11:30 a.m. The Resident's diagnosis included, but were not limited to, arthritis and degenerative disc disease of the lumbar spine.</p> <p>A physician's order, dated 5/26/23, indicated she was to receive hydrocodone- acetaminophen (narcotic pain medication) 7.5/325 mg (milligram) every 8 hours for pain.</p> <p>A physician's order, dated 7/15/23, indicated to hold the bedtime dose of hydrocodone/ acetaminophen and to monitor for 72 hours for adverse side effects.</p> <p>On 9/21/23 at 11:32 a.m. the DON provided a medication/ treatment error report dated 7/15/23 at 2:15 p.m., which indicated the QMA 4 administered the wrong medication. Resident C was given an oxycodone (narcotic pain medication) 7.5 mg/ 325 mg tablet instead of her ordered hydrocodone 7.5/ 325 mg. The physician and the family was notified. The physician gave an order to hold the hydrocodone for the night and to monitor for 72 hours for any adverse effects. QMA 4 was educated on the 3 checks</p>		<p>qualified to administer medication will be reeducated including but not limited to using the general dose preparation and medication administration assistance or observation policy. Staff qualified to assist with ADL care will be reeducated by DNS/designee on ADL documentation by 10/12/2023. Staff reeducation will include but not limited to ADL documentation.</p> <p>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: All residents have the potential to be affected. No resident was adversely affected. Staff qualified to administer medications reeducated by DNS/designee by 10/12/23. Staff qualified to administer medication will be reeducated to include but not limited to using the general dose preparation and medication administration assistance or observation policy. Staff qualified to assist with ADL care will be reeducated by DNS/designee on ADL documentation by 10/12/2023. Staff reeducation will include but not limited to ADL documentation. Medication pass observation tool, resident care/needs and ADL documentation monitoring tool, resident hospital and rehab return monitoring tool will be completed</p>	

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	<p>that should be performed before administering medications.</p> <p>c. The clinical record for Resident E was reviewed on 9/20/23 at 11:40 a.m. The Resident's diagnosis included, but were not limited to, hypertension.</p> <p>Resident E's clinical record indicated he was allergic to Lisinopril (high blood pressure medication).</p> <p>A physician's order dated 8/19/23 indicated to send Resident E to the hospital emergency room for further evaluation and treatment of vomiting and light headedness related to medication error.</p> <p>On 9/21/23 at 11:02 a.m., the DON provided a Medication/ Treatment Error Report, dated 8/19/23, which indicated that QMA 5 had given Resident E another resident's medication. Resident E had received lisinopril, which he was allergic to. Resident E was sent to the emergency room for evaluation. The physician was notified.</p> <p>A General Dose Preparation and Medication Administration, Assistance and Observation policy received on 9/21/23 at 1:01 p.m. from ED (Executive Director) indicated, the staff should only prepare medication for, or administer medications to, or observe, or assist only one resident at a time.</p> <p>2. A nursing note for Resident B dated 8/8/23 at 9:03 a.m. indicated, "Resident states that he wants assistance with showers, he states that he has onl[sic, only] had 1 shower since he has been back...writer reached out to [sic, name of Home Health agency], tech [sic] stated that they are working on getting him back on services, but he needs to be seen by his PCP[principal care</p>		<p>x4 weeks, then monthly x3 months. If 95% threshold is not met, then disciplinary action and new action will be completed. Monitoring tools will be completed by Director of Nursing or Executive Director/designee.</p> <p>By what date the systemic changes will be completed. 10/12/23</p> <p>-</p>	

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	<p>provider], writer called PCP office to make an appointment, tech [sic] states he has an appointment on 8/31 writer asked to make it sooner, made new appointment for 8/17 @ [sic, at] 2:40pm [sic, p.m.]..."</p> <p>Resident B's Evaluation Agreement for Residential Healthcare Services and Service Plan, both dated 4/25/23 indicated, Resident B required "standby assistance for bathing 3x [sic, three times] weekly."</p> <p>Resident B's clinical record, reviewed on 9/21/23 at 11:26 a.m. indicated, he had been discharged to the hospital on 6/24/23 and readmitted on 6/30/23.</p> <p>An interview with ADON HH (Assistant Director of Nursing) from the home health agency conducted on 9/21/23 at 4:03 p.m. indicated, Resident B was on their service for assistance with bathing prior to his hospitalization on 6/24/23. She indicated, when a resident has been discharged to a hospital, they (the home health agency) will put that Resident's services on hold until they return to the facility. In Resident B's case, his services were put on hold related to his hospitalization on 6/24/23 and incidentally, Resident B's certification period ended on 6/30/23. ADON from home health agency indicated, once the certification period has ended, the resident would need to get recertified for services which involves a physician's visit. The home health agency did not receive an order for Resident B until 9/5/23 for an evaluation and treatment. Resident B was off of home health services, which assisted him with bathing, from 6/30/23 until 9/5/23.</p> <p>ADON and DON (Director of Nursing) were unable to locate any shower sheets for Resident B</p>			

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	<p>for the month of August 2023.</p> <p>Resident B's shower sheets for September 2023 were received on 9/21/23 at 2:56 p.m. from ADON. The shower sheets indicated, Resident B received a bath/shower on the following dates: 9/8/23, 9/12/23, and 9/18/23.</p> <p>An interview with DON conducted on 9/21/23 at 2:56 p.m. indicated, facility staff, as well as home health staff, are to fill out a shower sheet even if the resident refuses or reschedules their shower.</p> <p>The facility's shower schedule dated 8/28/23 was received on 9/21/23 at 10:14 a.m. from ED (Executive Director) indicated, Resident B was to receive showers on Wednesdays and Saturdays. At the bottom of the shower schedule it reads, "Complete a shower sheet for each resident. If resident refuses, have the resident sign and notify the nurse. Place the completed shower sheet in the binder. Ensure the nurse has signed."</p> <p>This state tag relates to complaint IN00417592.</p>			