STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. BUILDING _____ B. WING _____	C 05/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE CENTER FOR WELLNESS AND REHAB	680 COLE STREET CARLISLE, IA 50047

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F 000	INITIAL COMMENTS Correction date_____ The following deficiency relates to the investigation of facility reported incident #67678 and complaint #67905 & #67902. (See Code Federal Regulations (42CFR) Part 483. Subpart B-C). Complaint #67906 & #68019 was not substantiated.	F 000		
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its- (f)(2) Residents are free of any significant medication errors. This Requirement is not met as evidenced by: Based on record review, and resident, family and staff member interviews, the facility failed to administer medications according to physician's order which resulted in a significant medication error for 1 of 7 resident records reviewed (Resident #1). The facility reported a census of 85 residents. Findings include: The Minimum Data Set (MDS) Assessment tool dated 2/19/17 revealed Resident #1 had diagnoses that included diabetes, Parkinson's disease, asthma and depression. Resident #1 had been admitted to the facility on 10/25/16. Resident #1 scored 9 out of 15 points possible on the Brief Interview for Mental Status cognitive test which indicated cognitive impairments but without	F 333		

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

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F 333	Continued From page 1 symptoms of delirium; and able to make self understood and understood others. The MDS revealed Resident #1 required extensive assistance by at least 1 staff member for transfers to and from bed and chair, dressing, bathing, toileting and personal hygiene and was unable to ambulate. The nursing care plan included problems identified as potential for fluid deficit related to medication use, diabetes. The care plan indicated a potential for depressive symptoms related to depression diagnosis; a potential for pain symptoms and nutritional deficits, and directed staff to administer medications as ordered. The care plan directed staff to monitor and document side effects and effectiveness of medications. According to Resident #1's Physician orders dated 3/10/17 directed staff to administer the following medications: Aspirin 81 milligrams (mg) administered oral daily at bedtime. Buproprion hydrochloride (an antidepressant) 300 mg extended release administered oral daily. Carbodopa/Levodopa (anti-Parkinson's medication) 25-100 mg administered oral daily. Combivent AER 20-100, 2 puffs inhaled by mouth 5 times daily. Duloxetine (an antidepressant) 20 mg administered oral daily. Finasteride (treats prostatic enlargement) 5 mg administered oral daily. Lasix (a diuretic) 20 mg administered oral 3 times weekly on Monday, Wednesday and Friday. Glucosamine/Chondroitin 500-400 tablet (supplement for arthritis treatment) oral daily. Oyster Shell/Vitamin D 500/200 mg tablet oral	F 333		

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F 333	Continued From page 2 daily. Miralax (laxative) 17 Grams in 4 - 8 ounces of water or juice daily. Simvastatin (anti-cholesterol) 40 mg administered oral daily Tamsulosin (eases urination) 0.4 mg administered oral daily. Thera Beta multivitamin with minerals tablet oral daily. Tradjenta (anti-diabetes) 5 mg administered oral daily Humalog insulin 20 units injected subcutaneously (under the skin) 3 times daily at meals. Lantus insulin 60 units injected subcutaneously daily at bedtime Humalog insulin administered subcutaneously 4 times daily on sliding scale related to blood glucose results, for blood glucose of 151 or above. The facility's self-reported incident described Resident #1 received another resident's medication (Resident #2) by mistake on the morning of 4/9/17. Record review revealed Staff A, licensed practical nurse (LPN), administered the following oral medications to Resident #1 on the morning of 4/9/17, the medications were labeled and ordered for Resident #2: 1. Aspirin 81 mg. 2. Baclofen (muscle relaxer) 30 mg. 3. Flexeril (muscle relaxer) 10 mg. 4. Dantrolene (muscle relaxer) 100 mg. 5. Dexilant (treats esophageal reflux) 60 mg. 6. Docusate Sodium (stool softener) 100 mg. 7. Lasix (diuretic) 40 mg.	F 333		

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F 333	Continued From page 3 8. Gabapentin (analgesic and anti-seizure) 200 mg. 9. KLOR-Con sprinkles (potassium supplement) 10 milliequivalents. 10. L-Arginine (amino acid) 500 mg. 11. Claritin (antihistamine) 10 mg. 12. Milk of Magnesia (laxative) 1 ounce. 13. Oxybutynin (anticholinergic that relaxes bladder muscles) 5 mg. 14. Oxycontin (narcotic analgesic) 30 mg CR (continuous release). 15. Miralax (laxative) 17 Grams in 8 ounces of water or juice. 16. Seroquel (antipsychotic) 50 mg 17. Sennalax-S (stool softener and laxative) 8.6-50 mg, 2 tablets. 18. Thera Beta multiple vitamin. An undated written statement signed by Staff A stated on 4/9/17 at 9:00 a.m., she administered Resident #2's medications to Resident #1 by error. She realized she made a mistake when she returned to the medication cart to prepare Resident #2's medications. She placed a phone call to Resident #1's physician and return a call at 9:15 a.m. by the provider on-call for the physician directed her to administer the routine medications to Resident #1 with exception of Oxybutynin and Duloxetene which were to be administered at bedtime. The physician directed her to observed the resident with hourly vital signs for 8 hours, if the resident became more somnolent they could transfer to the Emergency room at the hospital. A Nurse's Note transcribed by Staff A on 4/9/17 at 10:02 a.m. identified Resident #1 received another resident's medications (Resident #2) at 9:00 a.m., and the physician was notified.	F 333		

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F 333	Continued From page 4	F 333		

The next Nurse's Note entry on 4/9/17 at 1:53 p.m., also transcribed by Staff A, identified Resident #1 resident remained very lethargic, unable to open eyes or elicit verbal response. Resident #1's family concerned that resident was unresponsive and requested transfer to the Emergency Room. Staff called the ambulance for transport to the Emergency Room.

The Emergency Room physician progress note, dated 4/9/17 at 2:36 p.m., revealed the resident presented with altered mental status that began after he/she received another resident's medications at 9:00 a.m. The resident became increasingly drowsy with decreased responsiveness as the day progressed, with blood sugar of 79 and oxygen saturation of 89 percent on room air obtained en route by ambulance. The resident received Narcan with no changes to his/her mental status. The resident's condition improved with oxygen at 4 liters per minute per nasal cannula applied however remained somnolent in the Emergency Room (aroused to painful stimulus and voice). Resident #1 required hospital admission with cardiac monitor for altered mental status secondary to medication overdose. The resident remained hospitalized for the conditions until 4/11/17.

During an interview on 6/7/17 at 10:37 a.m., Staff A stated she thought the medication error with Resident #1 happened because she was distracted. She realized she had the MAR opened to Resident #1's record when she pulled Resident #2's medication dispensing cards. She noticed the medications for the 9th had already been

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F 333	Continued From page 5 dispensed when she had made the error. Staff A stated she had made medication errors before but not like the one on 4/9/17. During an interview on 6/12/17 at 3:30 p.m., the DON stated Staff A told her she hadn't looked at the MAR or read the medication dispensing cards when she interviewed her about the error. The DON also stated Resident #1's and Resident #2's medications were contained in the same drawer on the medication cart and the employee did not read the name on the cards before she dispensed the medications. During an interview on 6/7/17 at 6:25 a.m., Staff B, certified nursing assistant (CNA) and certified medication aide (CMA) stated when she dispensed medications she located the resident's medication dispensing cards labeled with the resident's name in the medication cart, compared the dispensing instruction on the dispensing card to the MAR and verified they were the same before she dispensed the medication. During an interview on 6/7/17 at 9:30 a.m., Staff C, CNA, stated she worked on the day shift on 4/9/17, the nurse (Staff A) directed the CNA's they had to keep an eye on the resident. Staff C stated they moved the resident to a recliner by the dining room after breakfast. Staff C stated normally the resident transferred with a stand lift but they had to perform a manual 2 man transfer because the resident was too lethargic and couldn't stand. Staff C stated the lethargy started around 10:30 a.m.	F 333		

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F 333	Continued From page 6 During an interview on 6/7/17 at 9:04 a.m., Staff D, CNA, stated she worked on the day shift on 4/9/17, they transferred the resident from a recliner chair to his/her power wheelchair with the stand lift before lunch. The resident didn't eat lunch, and manually transferred by 3 staff after lunch because the resident couldn't stand and they couldn't get the resident to respond. During an interview on 6/7/17, the resident's responsible party stated he/she was notified of the medication error a few hours after it had occurred. When they arrived at the nursing home the resident was very lethargic, didn't respond to questions and wouldn't wake up. He/she had to demand the resident's transfer to the Emergency Room, that Staff A kept telling him/her they could monitor the resident at the facility, but he/she volunteered as an Emergency Medical Technician and knew the resident needed to go to the hospital based on his/her worsening condition. During on interview on 6/7/17 at 3:02 p.m., the nurse practitioner at the resident's physician's office stated the medication error on 4/9/17 was a significant medication error and caused Resident #1's symptoms that required hospitalization and treatment. Staff A's personnel file revealed she was hired as an LPN on 8/10/16, and made a medication error on 1/20/17 when she administered 10.5 milligrams of Coumadin (a high dose of a blood thinning medication) to the wrong resident when the medication dispensing card was mixed up with the wrong resident's other medication dispensing cards. The resident required Aquamephyton (a medication used to clot or	F 333		

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F 333	Continued From page 7 thicken blood) 2.5 milligrams administered oral 1 time. The Medication Error Report form that described the incident directed the employee to pay more attention to the names on the medication dispensing cards. During an interview on 6/12/17 at 3:30 p.m., the Director of Nursing (DON) identified the staff member received disciplinary action or the medication error because it was her 1st medication error. The facility's Medication Administration Policy dated as last reviewed on 12/18/12 directed staff: 1. Identify resident by pictures and check the medication administration record (MAR). Check to see if the resident has any allergies. Each medication is to be verified for right dose, right medication, and right time, as well as right route by comparing the label on the medication container to the MAR. 2. Read the label 3 times before dispensing medication into the medication cup: a. When taking from the drawer. b. Before pouring it (removal from dispensing container). c. When putting container back in drawer.	F 333		