STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING _____ B. WING _____	**06/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUBURN VILLAGE	**1751 WESLEY ROAD AUBURN, IN 46706**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was free of significant med error administration when an anti-convulsant medication was not given as ordered by the physician for 1 of 3 residents reviewed (Resident T). After missing 3 doses of medication, the resident experienecedd a siezure that resulted in injury. Findings include: On 6/5/20 at 1:15 P.M., Resident T's record was reviewed. [DIAGNOSES REDACTED]. The resident had been admitted to the facility recently, following hospitalization for [MEDICAL CONDITIONS] (death of brain cells due to complete lack of oxygen). While hospitalized , the resident was started on anti-convulsant medication for [MEDICAL CONDITION]. A Care Plan, dated 4/30/20, indicated the resident was at risk for injury related to [MEDICAL CONDITION] disorder of [MEDICAL CONDITION]. The goal was the resident would remain free from serious injury related to his [MEDICAL CONDITION] disorder. Interventions included, but were not limited to, administer medications as ordered. On 6/5/20 at 2:27 P.M., Resident T's family member was interviewed by phone. The family member expressed concern about the resident having bitten his tongue during a [MEDICAL CONDITION] and was treated at the facility. An NP (Nurse Practitioner) Progress note, dated 5/1/20 at 9:34 a.m., indicated the resident was newly admitted to the facility. He had a history of [REDACTED]. An NP Progress note, dated 5/5/20 at 8:54 a.m., indicated the resident was seen for a visit after staff reported the resident was having continual [MEDICAL CONDITION] and had a piece of his tongue between clenched teeth. The nurse and RT (Respiratory Therapist) attempted to unclench his jaw using tongue depressors but were unsuccessful. [MEDICATION NAME] was ordered to relax his jaw so that his tongue could be placed back behind his teeth which was bleeding and dark purple. After the effects of the [MEDICATION NAME] began, Resident T began to relax his jaw and unclench his teeth. He was found to have bitten this part of his tongue off. The resident was having [MEDICAL CONDITION] activity and his [MEDICAL CONDITION] medications were to be reviewed and changed as needed to get his [MEDICAL CONDITION] under control. A Nurse Progress note, dated 5/5/20 at 1:07 p.m., indicated during the morning assessment, the resident was found to have blood coming from his mouth. His teeth were clamped down tight and he was biting his tongue. The nurse attempted to have the resident open his mouth without success. The NP, who was in the room, ordered the resident to be given [MEDICATION NAME] (anti-anxiety) 4 mg (milligrams) IM (intramuscularly) to see if he would relax his jaw and release his tongue. After the [MEDICATION NAME] was administered, his jaw relaxed and he released his tongue. Hospital discharge orders, dated 4/30/20 at 11:47 a.m., indicated the resident was to be administered [MEDICATION NAME] (anti-convulsant) 20 mg/5 ml [MEDICATION NAME]-give 15 ml (milliliter) via gastrostomy tube every 12 hours. Review of the May 2020 MAR (Medication Administration Record) indicated the resident had not received [MEDICATION NAME] 20 mg/5 ml [MEDICATION NAME]-give 15 ml (milliliter) via gastrostomy tube every 12 hours as ordered on 5/1 at 8:00 a.m. or 8:00 p.m. and 5/2/20 at 8:00 a.m. for a total of 3 omitted doses. The MAR indicated [REDACTED].M., contrainindications/precautions information for [MEDICATION NAME] was retrieved from the webpage PDR.net (Prescribers' Digital Reference) which indicated the following: Abrupt discontinuation .Sudden, abrupt discontinuation of [MEDICATION NAME] in epileptic patients may precipitate acute [MEDICAL CONDITION] On 6/5/20 at 3:49 P.M., RN 2 was interviewed. During the interview, she indicated she had not administered [MEDICATION NAME] on 5/1 or 5/2/20 because it hadn't come in from the pharmacy. On 6/5/20 at 4:08 P.M., the MDS (Minimum Data Set) nurse was interviewed. She indicated she had not administered [MEDICATION NAME] to the resident the morning of 5/1/20 because it had been unavailable from the pharmacy and it was not a medication that the facility had on hand in their EDK (emergency drug kit). On 6/8/20 at 12:54 P.M., the DON (Director of Nursing) was interviewed. During the interview, she indicated medications should be given as ordered by the physician. If [MEDICATION NAME] was not available from the pharmacy, the physician or NP should have been notified. This Federal tag relates to Complaint IN 454. 3.1-48(c)(2)

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