STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDMOOR OF EVANSVILLE LLC	6521 GREENDALE DR, EVANSVILLE, , 47711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00411492. Complaint IN00411492 - State deficiencies related to the allegations are cited at R0246 & R0349. Survey date: June 27, 28 & 29, 2023 Facility number: 010681 Residential Census: 89 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 5, 2023.	R 0000		
R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon	R 0246	R0246: This Plan of Correction is neither an agreement with nor an admission	07/22/2023

	authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interviews and record review, the facility failed to ensure that QMA's (Qualified Medication Aides) obtained authorization by a licensed nurse for the administration of a PRN (as needed) medication for 1 of 6 residents reviewed (Resident W). Findings include: On 6/29/24, Resident W's clinical record was reviewed. Diagnoses included, but were not limited to, psychoactive substance dependence, alcohol dependence with intoxication. Current physician's orders included, but were not limited to, Oxycodone HCL oral tablet 10 mg, give 1 tablet by mouth every 8 hours as needed at nurse discretion.		of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of July 22th, 2023 and requests paper compliance for this survey. Residents who were provided care by QMA's were reviewed. No negative outcomes were identified based upon the documentation review. 100% of residents who received services by QMA's were reviewed. No negative outcomes were identified based upon the review of resident documentation and incident reports. The QMA scope of practice was reviewed with nurses and QMAs on staff to educate them on the limitations of the QMA scope, as well as the need for documentation by a nurse for PRN authorization and administration immediately. A binder was created with PRN documentation sheets for each resident to have the nurse physical signature at time of authorization being given to QMA for administration. The Health and Wellness Director or designee will review 100% of all PRN medication and treatment administrations	

	Resident W's eMAR (electronic Medication Administration Record) was reviewed for Oxycodone HCL oral tablet and indicated the following doses were administered by QMA 4: 6/1/23 at 12:00 P.M. 6/5/23 at 8:00 A.M. 6/5/23 at 12:00 P.M. 6/6/23 at 8:00 A.M. Progress notes for June of 2023 were reviewed and lacked documentation of a nurse authorizing QMA 4 to give PRN Oxycodone HCL and assessments of the effectiveness of the drugs given. Resident was discharged from the facility on 6/6/23. During an interview on 6/28/23 at 3:00 P.M. with the DON (Director of Nursing), she indicated if a QMA gives a PRN medication, they must first ask permission from a nurse and then they can give it. The administration is documented on the eMAR once it is given. The nurse must note the effectiveness of the medication and this has to be done within the shift the medication was given. No QMA may be permitted to assess the effectiveness of the PRN medication. Facility policy (revised 2/2/2020)		by QMA's for 30 days. The Health and Wellness Director will review 50% of all PRN medication and treatment administrations by QMA's for days 31-60. The Health and Wellness Director will review 25% of all PRN medication and treatment administrations by QMA's for the days 61-90.	

indicated that QMA's may administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following:

A. Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred.

B. Document in the resident record that the facility's licensed nurse was contacted, symptoms were described and permission was granted to administer the medication, including the time of contact.

C. Obtain permission to administer the medication each time the symptoms occur in the resident

D. Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty.

This State Residential Finding relates to Complaint IN00411492.

Based on interviews and record review, the facility failed to ensure that QMA's (Qualified Medication Aides) obtained authorization by a licensed

nurse for the administration of a PRN (as needed) medication for 1 of 6 residents reviewed (Resident W).

Findings include:

On 6/29/24, Resident W's clinical record was reviewed. Diagnoses included, but were not limited to, psychoactive substance dependence, alcohol dependence with intoxication.

Current physician's orders included, but were not limited to, Oxycodone HCL oral tablet 10 mg, give 1 tablet by mouth every 8 hours as needed at nurse discretion.

Resident W's eMAR (electronic Medication Administration Record) was reviewed for Oxycodone HCL oral tablet and indicated the following doses were administered by QMA 4:

6/1/23 at 12:00 P.M.

6/5/23 at 8:00 A.M.

6/5/23 at 12:00 P.M.

6/6/23 at 8:00 A.M.

Progress notes for June of 2023 were reviewed and lacked documentation of a nurse authorizing QMA 4 to give PRN Oxycodone HCL and assessments of the effectiveness of the drugs given. Resident was discharged from

	the facility on 6/6/23. During an interview on 6/28/23 at 3:00 P.M. with the DON (Director of Nursing), she indicated if a QMA gives a PRN medication, they must first ask permission from a nurse and then they can give it. The administration is documented on the eMAR once it is given. The nurse must note the effectiveness of the medication and this has to be done within the shift the medication was given. No QMA may be permitted to assess the effectiveness of the PRN medication. Facility policy (revised 2/2/2020) indicated that QMA's may administer previously ordered pro re nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or on call. If authorization is obtained, the QMA must do the following: A. Document in the resident record symptoms indicating the need for the medication and time the symptoms occurred. B. Document in the resident record that the facility's licensed nurse was contacted, symptoms were described and permission was granted to administer the medication, including the time of contact. C. Obtain permission to			

	administer the medication each time the symptoms occur in the resident D. Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty. This State Residential Finding relates to Complaint IN00411492.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure that medication orders were correctly transcribed from the physician's order to the resident's eMAR (electronic Medication Administration Record) on 1 of 6 residents.	R 0349	R0349: This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of July 26th, 2023 and requests paper compliance for this survey. Resident cited in the deficiency is no longer a resident of the facility. All new admissions will follow the medication reconciliation policy going forward. All medication orders were reviewed for transcription	07/26/2023

	(Resident K) Findings include: On 6/27/23 at 11:30 A.M., Resident K's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's Disease and Type 2 diabetes mellitus. Current physician orders dated 5/12/23 include, but were not limited to, "Aricept 10 mg (Milligrams), give 1 tablet one time a day for Dementia. Res has Aricept 5 mg on hand. Give 2 to equal 10 mg DOSE!!!" Admitting Physician/Healthcare Provider Plan of Care, dated 2/1/23 indicated Resident K was to receive Aricept 5 mg one pill orally at night. On 6/29/23 at 11:30 AM, the ADON (Assistant Director of Nursing) provided a copy of an After-Visit Summary from physician office, dated 2/21/23, indicated the resident was taking Aricpet 5 mg 1 pill orally at night. Medication Administration Records reviewed for February, March, April, and until May 12, 2023 indicated Resident K was getting Aricept 10 mg at bedtime. During on interview on 6/28/23 at 9:15 A.M., the DON (Director of Nursing) indicated orders for		errors. A medication Reconciliation policy was created and all nurse’s/qma’s were educated through in-service. Medication reconciliation policy will be reviewed each month at the monthly all staff meeting. The director of nursing or designee will audit medication reconciliation performed on 100% of admissions for 30 days, 50% for 31-60 days, and 25% for 61-90 days. This will be completed PRN thereafter. All phone orders will be reviewed by director of nursing or designee within 24 hours of receiving.	

drugs were received from the Physician on the physician/healthcare provider plan of care at admission.

On 6/29/23 at 11:30 A.M., a current Medication Management Program policy was provided, and indicated "Medication reconciliation is the process of creating the most current, complete, and accurate medication list possible...involves comparing the resident's current with those ordered .... or moving from home into a care setting...Prior to move in, the community should obtain a copy of the medication the resident was taking from the resident's prior care setting and/or home."

This State Residential Finding relates to Complaint IN00411492.

Based on record review and interview, the facility failed to ensure that medication orders were correctly transcribed from the physician's order to the resident's eMAR (electronic Medication Administration Record) on 1 of 6 residents. (Resident K)

Findings include:

On 6/27/23 at 11:30 A.M., Resident K's clinical record was reviewed. Diagnoses included, but were not limited to, Parkinson's Disease and Type 2

diabetes mellitus.

Current physician orders dated 5/12/23 include, but were not limited to, "Aricept 10 mg (Milligrams), give 1 tablet one time a day for Dementia. Res has Aricept 5 mg on hand. Give 2 to equal 10 mg DOSE!!!"

Admitting Physician/Healthcare Provider Plan of Care, dated 2/1/23 indicated Resident K was to receive Aricept 5 mg one pill orally at night.

On 6/29/23 at 11:30 AM, the ADON (Assistant Director of Nursing) provided a copy of an After-Visit Summary from physician office, dated 2/21/23, indicated the resident was taking Aricpet 5 mg 1 pill orally at night.

Medication Administration Records reviewed for February, March, April, and until May 12, 2023 indicated Resident K was getting Aricept 10 mg at bedtime.

During on interview on 6/28/23 at 9:15 A.M., the DON (Director of Nursing) indicated orders for drugs were received from the Physician on the physician/healthcare provider plan of care at admission.

On 6/29/23 at 11:30 A.M., a current Medication Management Program policy was provided, and indicated "Medication

	reconciliation is the process of creating the most current, complete, and accurate medication list possible...involves comparing the resident's current with those ordered .... or moving from home into a care setting...Prior to move in, the community should obtain a copy of the medication the resident was taking from the resident's prior care setting and/or home." This State Residential Finding relates to Complaint IN00411492.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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