STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STORYPOINT FORT WAYNE WEST	611 W COUNTY LINE RD SOUTH, FORT WAYNE, , 46814

(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 IN00382359. Complaint IN00382359 - Substantiated. State deficiencies related to the allegations are cited at R0064. Survey date: July 21, 2022 Facility number: 011804 Residential Census: 99 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 26, 2022	R 0000	This Plan of Correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Storypoint Fort Wayne West as to the accuracy of the surveyor’s findings or the conclusions drawn.	
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his	R 0064	The two residents affected by the deficient practice were monitored for signs/symptom of adverse reactions. The misappropriated medication is being billed to the Community for payment.	08/19/2022

	or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on observation, interview, and record review the facility failed to ensure resident property was secure for 2 of 3 residents reviewed. Findings include: During an interview on July 21, 2022, at 8:40 am, Qualified Medication Assistant 1, (QMA) indicated the narcotic administration policy was to match the order with the medication card or bottle and the count sheet before giving. She indicated narcotics were to be counted at every shift change. Recently, however, there were missing pages from the narcotic book and staff had been educated related to the importance of maintaining an accurate count of medication cards, number of pills contained in the cards, pill bottles, and count sheets. QMA 1 indicated most of the staff had a suspicion someone was misappropriating narcotics. In an interview on July 21. 2022, at 8:50 am, the Director of Health Services, (DHS) , indicated law enforcement was notified of missing narcotics on two separate occasions. She		The Community realizes that all residents with orders for controlled substances have the potential to be affected by the deficient practice. Residents with orders for controlled substances were reviewed along with the narcotics sheets. No other residents were identified to have been affected. An investigation was initiated immediately by the ED/Wellness Director. An incident report was submitted to the State on 6/07/2022. (Please see Exhibit A) An in-service education was held for licensed staff and QMA's on June 6, 2022. The in-service included but was not limited to: Standard Operating Procedures (SOP) on Missing/Stolen Drugs. (Please see Exhibit B). Another in-service education will be held prior to 8/19/2022 for all licensed nurses and QMA's. The Wellness Director/designee will monitor the Controlled substance Count Sheet 5 times weekly for the next 6 months. All findings will be forwarded monthly for the next 6 months to the Executive Director/Quality Assurance Committee for further review and recommendations as needed.	

indicated narcotic count sheets and narcotic medications were noted missing during a training session on June 2, 2022, and on June 6, 2022. She indicated LPN 1 was suspected of narcotic diversion. She indicated LPN 1 made a comment in reference to the narcotic investigation. She indicated LPN 1 had made a comment in reference to having been to the dentist recently so she would be covered for a drug screen. She indicated LPN 1 was currently employed performing office duties and other staff had been instructed LPN 1 was not to be granted access to the medication keys. She indicated LPN 1 was scheduled to work but had not yet arrived.

In an interview on July 21, 2022, at 9:10 am, the Executive Director, (ED) indicated LPN 1 was suspected of narcotic diversion. She indicated LPN 1 had been witnessed wearing a cross body bag and locking it in the narcotic drawer. She indicated LPN 1 had the medication keys in the days prior to the incident of missing narcotics. She indicated LPN 1 had on one occasion, asked a QMA for the narcotic keys to verify a resident medication. She indicated LPN 1 made a comment in reference to a drug screen; indicating LPN 1 would be covered due to having a prior prescription from a dental visit.

She indicated other staff had reported suspicions LPN 1 administered a lot of narcotics. She indicated LPN 1's initial drug screen sample was declined due to not being in the correct temperature range, LPN 1 was unable to provide another sample until much later, and the final drug screen result was not immediately available as in the case of the other drug screen results. The ED indicated she was not aware of the Impaired Nurse Program.

In an interview on July 21, 2022, at 10:05 am, the DHS, indicated she and LPN1 rode together to the drug screening site. She indicated they were at the screening facility for 6 hours due to LPN 1 submitting a sample that was not within the appropriate temperature range and LPN 1 was unable to submit another sample until much later in the day. The DHS denied making LPN 1 aware of the drug screen prior to LPN 1 arriving. She indicated LPN 1 lived near the facility but LPN 1 had arrived much later than expected.

A review of a narcotic count log dated May 2022 indicated 42 out of 130 opportunities to count narcotics were missed.

A review of a narcotic shift count log indicated on May 20, 2022, from 6:00 am through May 21,

2022, at 2:00 pm there were 19 narcotic cards. On May 21, 2022, at 2:00 pm, LPN 1 was the oncoming nurse. On May 21, 2022, at 10:00 pm there were 17 narcotic cards. On May 21, 2022, at 10:00 pm, LPN 1 was the off going nurse. On May 27, 2022, at 10:00 pm, a narcotic shift count log indicated there were 18 narcotic cards. On May 28, 2022, at 6:00 am, the narcotic card count was illegible. There were no record of shift counts from May 28, 2022, from 2:00 pm through May 30, 2022 at 10 pm. On May 31, 2022, at 6:00 am, the number of narcotic cards was written over to indicate there were 15 cards. LPN 1 was the oncoming nurse at 6:00 am on May 31, 2022. On May 31, 2022, at 2:00 pm, there were 15 narcotic cards. LPN 1 was the off going nurse.

A review of LPN 1's drug screen result indicated the sample was collected on June 7, 2022. The final result dated June 20, 2022, was negative. Medical Review Officer (MRO) remarks indicated the sample was a dilute specimen and was MRO negative.

During an interview on July 21, 2022, at 12:20 pm, the DHS indicated she was aware of missing documentation related to shift change narcotic counts. She indicated she had been

educating staff about the importance of narcotic counts. She indicated she was unaware of a narcotic discrepancy form until today but would implement the form.

During an interview on July 21, 2022, at 2:20 pm, LPN 1 indicated she was familiar with narcotic administration as she had been a nurse for 15 years. She indicated she was aware of a missing narcotics investigation. She denied ever being suspected of drug diversion or being involved in a drug diversion investigation. She indicated she did not attend the narcotic count training.

A policy titled "Controlled Substance and Preventing Drug Theft" indicated a controlled substance count discrepancy form should be utilized to monitor counts.

A policy titled "Missing/Stolen Drug" indicated that narcotics were to be counted by the oncoming and off going staff. The policy indicated both staff members were to confirm accuracy by signing the controlled substance count sheet.

This State finding is related to complaint IN00382359.

Based on observation, interview, and record review the facility failed to ensure resident

property was secure for 2 of 3 residents reviewed.

Findings include:

During an interview on July 21, 2022, at 8:40 am, Qualified Medication Assistant 1, (QMA) indicated the narcotic administration policy was to match the order with the medication card or bottle and the count sheet before giving. She indicated narcotics were to be counted at every shift change. Recently, however, there were missing pages from the narcotic book and staff had been educated related to the importance of maintaining an accurate count of medication cards, number of pills contained in the cards, pill bottles, and count sheets. QMA 1 indicated most of the staff had a suspicion someone was misappropriating narcotics.

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investigation. She indicated LPN 1 had made a comment in reference to having been to the dentist recently so she would be covered for a drug screen. She indicated LPN 1 was currently employed performing office duties and other staff had been instructed LPN 1 was not to be granted access to the medication keys. She indicated LPN 1 was scheduled to work but had not yet arrived.

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final drug screen result was not immediately available as in the case of the other drug screen results. The ED indicated she was not aware of the Impaired Nurse Program.

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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