STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST, CHARLESTOWN, , 47111

(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 Complaints IN00368758 and IN00369533. Complaint IN00368758 - Substantiated. State deficiencies related to the allegation is cited at R0064. Complaint IN00369533 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey date: January 3 and 4, 2022 Facility number: 012007 Residential Census: 90 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 6, 2022.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit.	

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 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 interview and record review, the facility failed to ensure misappropriation of resident property did not occur for 2 of 3 residents reviewed for resident rights. (Residents B and C) Findings include: 1. The clinical record for Resident B was reviewed on 1/3/22 at 11:45 a.m. Diagnosis included, but was not limited to, multiple sclerosis. The incident report, dated 12/9/21 at 10:17 p.m., indicated Resident B had narcotic pain medication signed out. The resident was cognitively intact and reported she did not take the medication at the times it was signed out. The physician order, dated 3/3/18, indicated the resident was to receive Hydrocodone-Acetaminophen	R 0064	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Missing narcotic medication for residents B and C have been replaced at facility expense. 2. Narcotic audit to be completed for all residents receiving narcotic medications by 1/20 to ensure all narcotics match sign out sheet. All residents, including B and C, have been informed of resident rights, including freedom from misappropriation of personal items and	01/28/2022

	(narcotic pain medication) 7.5 mg (milligrams)/ 325 mg every 6 hours as needed for pain. The December 2021 individual narcotic record indicated the narcotic pain medication was administered by LPN (Licensed Practical Nurse) 3 on 12/9/21 at 12:00 a.m. During an interview on 1/3/22 at 1:02 p.m., Resident B indicated she slept all night and had not requested pain medication in the middle of the night on 12/9/21. 2. The clinical record for Resident C was reviewed on 1/3/22 at 12:15 p.m. Diagnosis included, but was not limited to, diabetes. The incident report, dated 12/9/21 at 10:17 p.m., indicated the resident had requested narcotic pain medication on 12/9/21, but was unable to receive as the medication was signed out at 5:00 a.m. The resident reported she did not receive pain medication at 5:00 a.m. The physician order, dated 8/19/21, indicated the resident was to receive Hydrocodone-Acetaminophen 7/5/325 mg every 4 hours as needed for pain. The abuse investigation report, dated 12/9/21, indicated the		medication administration. 3. QMA/LPN/RN in-serviced on resident rights, including misappropriation of personal items and medication administration, by 1/28/2022. Education will be ongoing with agency and new hires prior to first shift regarding resident rights, freedom from misappropriation, and medication administration. 4. DON/designee will audit agency orientation, including misappropriation of property and medication administration. Narcotic count audits will be conducted to identify any potential further incidents of misappropriation of property related to medications as follows: 3/week for 4 weeks, 2/week for 4 weeks, 1/week for 2 months, then monthly for 2 months. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine	

	resident had requested pain medication on 12/9/21 at 7:00 a.m. The resident was told it was too early. The resident reported she had last had the pain medication at 7:00 p.m. on 12/8/21. Review of the December 2021 controlled drug record indicated LPN 3 administered the narcotic pain medication on 12/8/21 at 7:00 p.m. and 12/9/21 at 12:00 a.m. and 5:00 a.m. During an interview on 1/4/22 at 10:40 a.m., Resident C indicated she had requested pain medication the morning of 12/9/21 and was told it was too early to receive. She indicated she had not received any and knew she could have the medication every 4 hours. Resident B had intact cognition. On 1/3/22 at 1:12 p.m., the Director of Nursing provided a current copy of the document titled "Abuse, Prevention and Prohibition Policy" dated 4/2020. It included, but was not limited to, "Policy...The facility ...prohibits misappropriation of resident property...Definitions...Misappropriation of Resident Property is defined as the deliberate misplacement...temporary or permanent use of a resident's belongings...without the resident's consent...."		if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

This State tag relates to Complaint IN00368758

Based on interview and record review, the facility failed to ensure misappropriation of resident property did not occur for 2 of 3 residents reviewed for resident rights. (Residents B and C)

Findings include:

1. The clinical record for Resident B was reviewed on 1/3/22 at 11:45 a.m. Diagnosis included, but was not limited to, multiple sclerosis.

The incident report, dated 12/9/21 at 10:17 p.m., indicated Resident B had narcotic pain medication signed out. The resident was cognitively intact and reported she did not take the medication at the times it was signed out.

The physician order, dated 3/3/18, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 7.5 mg (milligrams)/ 325 mg every 6 hours as needed for pain.

The December 2021 individual narcotic record indicated the narcotic pain medication was administered by LPN (Licensed Practical Nurse) 3 on 12/9/21 at 12:00 a.m.

During an interview on 1/3/22 at

1:02 p.m., Resident B indicated she slept all night and had not requested pain medication in the middle of the night on 12/9/21.

2. The clinical record for Resident C was reviewed on 1/3/22 at 12:15 p.m. Diagnosis included, but was not limited to, diabetes.

The incident report, dated 12/9/21 at 10:17 p.m., indicated the resident had requested narcotic pain medication on 12/9/21, but was unable to receive as the medication was signed out at 5:00 a.m. The resident reported she did not receive pain medication at 5:00 a.m.

The physician order, dated 8/19/21, indicated the resident was to receive Hydrocodone-Acetaminophen 7/5/325 mg every 4 hours as needed for pain.

The abuse investigation report, dated 12/9/21, indicated the resident had requested pain medication on 12/9/21 at 7:00 a.m. The resident was told it was too early. The resident reported she had last had the pain medication at 7:00 p.m. on 12/8/21.

Review of the December 2021 controlled drug record indicated LPN 3 administered the narcotic pain medication on 12/8/21 at

	7:00 p.m. and 12/9/21 at 12:00 a.m. and 5:00 a.m. During an interview on 1/4/22 at 10:40 a.m., Resident C indicated she had requested pain medication the morning of 12/9/21 and was told it was too early to receive. She indicated she had not received any and knew she could have the medication every 4 hours. Resident B had intact cognition. On 1/3/22 at 1:12 p.m., the Director of Nursing provided a current copy of the document titled "Abuse, Prevention and Prohibition Policy" dated 4/2020. It included, but was not limited to, "Policy...The facility ...prohibits misappropriation of resident property...Definitions...Misappropriation of Resident Property is defined as the deliberate misplacement...temporary or permanent use of a resident's belongings...without the resident's consent...." This State tag relates to Complaint IN00368758			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the:	R 0243	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the	01/28/2022

	(A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on interview and record review, the facility failed to ensure a resident's (Residents B and C) record accurately reflected the administration of narcotics for 2 of 3 residents reviewed for medication administration. Findings include: 1. The clinical record for Resident B was reviewed on 1/3/22 at 11:45 a.m. Diagnosis included, but was not limited to, multiple sclerosis. The physician order, dated 3/3/18, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 7.5 mg (milligrams)/ 325 mg every 6 hours as needed for pain. Review of the December 2021 narcotic record indicated Resident B received the pain medication 12/3/21, 12/7/21, 12/8/21, 12/9/21, 12/14/21, and 12/16/21.		statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Residents assumed to be resident B and C have had MARs and Narcotic count sheets reviewed for accuracy. All missing documentation now noted in each resident's record. 2. Audit to be completed for all residents receiving PRN medications to either identify missing documentation of a PRN on the MAR or a discrepancy between the narcotic count sheet and MAR PRN documentation by 1/28/22. 3. All QMA/LPN/RN personnel in-serviced on PRN administration and documentation by 1/28/2022. In-servicing to focus on medication preparation and general guidelines, proper documentation of PRN medication, and controlled substance documentation according to community policy and procedure. In addition, all	

	The December 2021 medication administration record (MAR) lacked documentation of the administration of the narcotic pain medication on the above dates. During an interview on 1/3/22 at 4:00 p.m., the Director of Nursing indicated when a resident received an as needed narcotic pain medication, the medication should be signed out on the medication administration record. 2. The clinical record for Resident C was reviewed on 1/3/22 at 12:15 p.m. Diagnosis included, but was not limited to, diabetes. The physician order, dated 8/19/21, indicated the resident was to receive Hydrocodone-Acetaminophen 7/5/325 mg every 4 hours as needed for pain. The December 2021 controlled drug record indicated the narcotic pain medication was administered on the following dates: -12/06/21 at 7:00 a.m. -12/08/21 at 11:00 a.m. and 7:00 p.m. -12/09/21 at 12:00 a.m., 5:00 a.m., and 10:30 p.m.		agency nurses and QMAs will also be in-serviced on the above noted topics prior to their initial shift in building. 4. PRN medication audits will be conducted to identify completeness of PRN documentation needed 3/week for 4 weeks, 2/week for 4 weeks, 1/week for 2 months, then monthly for 2 months. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. DON/Designee will audit for agency in-service completeness after each initial shift filled by agency nurse or QMA ongoing. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

	-12/10/21 at 9:25 p.m. -12/11/21 at 9:00 a.m. -12/12/21 at 1:30 a.m. -12/15/21 at 9:41 p.m. -12/16/21 at 9:30 p.m. -12/19/21 at 11:00 p.m. -12/22/21 at 11:00 a.m. -12/25/21 at 1:00 p.m. -12/28/21 at 2:00 a.m. -12/31/21 at 3:30 a.m. and 8:00 a.m. The December 2021 medication administration record lacked documentation of the administration of the narcotic pain medication on the above dates and times.			

On 1/3/22 at 4:55 p.m., the Director of Nursing provided a current copy of the document titled "Preparation and General Guidelines" dated 1/2017. It included, but was not limited to, "Documentation...The individual who administers the medication dose record the administration on the resident's MAR directly after the medication is given...When PRN medications are administered, the following documentation is provided...Date and time of administration...."

Based on interview and record review, the facility failed to ensure a resident's (Residents B and C) record accurately reflected the administration of narcotics for 2 of 3 residents reviewed for medication administration.

Findings include:

1. The clinical record for Resident B was reviewed on 1/3/22 at 11:45 a.m. Diagnosis included, but was not limited to, multiple sclerosis.

The physician order, dated 3/3/18, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 7.5 mg (milligrams)/ 325 mg every 6 hours as needed for pain.

Review of the December 2021 narcotic record indicated

	Resident B received the pain medication 12/3/21, 12/7/21, 12/8/21, 12/9/21, 12/14/21, and 12/16/21. The December 2021 medication administration record (MAR) lacked documentation of the administration of the narcotic pain medication on the above dates. During an interview on 1/3/22 at 4:00 p.m., the Director of Nursing indicated when a resident received an as needed narcotic pain medication, the medication should be signed out on the medication administration record. 2. The clinical record for Resident C was reviewed on 1/3/22 at 12:15 p.m. Diagnosis included, but was not limited to, diabetes. The physician order, dated 8/19/21, indicated the resident was to receive Hydrocodone-Acetaminophen 7/5/325 mg every 4 hours as needed for pain. The December 2021 controlled drug record indicated the narcotic pain medication was administered on the following dates: -12/06/21 at 7:00 a.m.			

	-12/08/21 at 11:00 a.m. and 7:00 p.m. -12/09/21 at 12:00 a.m., 5:00 a.m., and 10:30 p.m. -12/10/21 at 9:25 p.m. -12/11/21 at 9:00 a.m. -12/12/21 at 1:30 a.m. -12/15/21 at 9:41 p.m. -12/16/21 at 9:30 p.m. -12/19/21 at 11:00 p.m. -12/22/21 at 11:00 a.m. -12/25/21 at 1:00 p.m. -12/28/21 at 2:00 a.m. -12/31/21 at 3:30 a.m. and 8:00 a.m. The December 2021 medication administration record lacked documentation of the administration of the narcotic pain medication on the above dates and times. On 1/3/22 at 4:55 p.m., the Director of Nursing provided a current copy of the document titled "Preparation and General Guidelines" dated 1/2017. It included, but was not limited to, "Documentation...The individual who administers the medication dose record the administration on the resident's MAR directly			

	after the medication is given...When PRN medications are administered, the following documentation is provided...Date and time of administration...."			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview and record review, the facility failed to ensure resident's (Resident G) medications were administered within an appropriate time frame for 1 of 3 residents reviewed for pharmacy services. Findings include: The clinical record for Resident G was reviewed on 1/4/22 at 11:20 a.m. Diagnoses included, but were not limited to, traumatic incomplete cord injury and neuropathy impulse disorder.	R 0296	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit. 1. Resident G has had medication times reviewed and adjusted by nurse practitioner to comply with physician order as written. 2. Audit to be completed by 1/28/22 to ensure that all resident medications are administered within proper timeframes as written in specific physician order. 3.	01/28/2022

	On 1/4/22 at 10:25 a.m., the Director of Nursing provided a copy of a flyer provided to the residents which indicated medication times would be adjusted in January 2022. The physician order, dated 12/8/19, indicated the resident was to receive Baclofen (muscle relaxer) 10 mg (milligrams) four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 7:00 p.m. Review of the January 2022 medication administration record indicated the medication times for the Baclofen were changed to 8:00 a.m., 12:00 p.m., 4:00 p.m., and 6:00 p.m. The medication was administered at those times on 1/1/22 and 1/2/22. During an interview on 1/3/22 at 4:25 p.m., Nurse Practitioner 2 indicated she had given verbal consent to change medication times, however, giving the Baclofen at 4:00 p.m. and 6:00 p.m. was not appropriate and would need to be re-evaluated for the administration time. On 1/4/22 at 10:35 a.m., the Director of Nursing provided a current copy of the document titled "Preparation and General Guidelines" dated 1/2017. It included, but was not limited to, "Policy...Medications are administered...in accordance with good nursing principles and		Staff to be in-serviced on Medication administration times by 1/28/2022. 4. Resident medication orders and MARs will be audited for changes in medication times that are inconsistent with order as written 3/week for 4 weeks, 2/week for 4 weeks, 1/week for 2 months, then monthly for 2 months. ED/Designee and DON/Designee will review audits with QA Committee monthly x3 months for identified issues. QA Committee will determine if audits necessitate extension past 3 months and will continue to review audit results monthly for duration of the extended timeframe as applicable.	

practices...FIVE RIGHTS...right time, are applied for each medication being administered...."

Based on interview and record review, the facility failed to ensure resident's (Resident G) medications were administered within an appropriate time frame for 1 of 3 residents reviewed for pharmacy services.

Findings include:

The clinical record for Resident G was reviewed on 1/4/22 at 11:20 a.m. Diagnoses included, but were not limited to, traumatic incomplete cord injury and neuropathy impulse disorder.

On 1/4/22 at 10:25 a.m., the Director of Nursing provided a copy of a flyer provided to the residents which indicated medication times would be adjusted in January 2022.

The physician order, dated 12/8/19, indicated the resident was to receive Baclofen (muscle relaxer) 10 mg (milligrams) four times a day at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 7:00 p.m.

Review of the January 2022 medication administration record indicated the medication times for the Baclofen were changed to 8:00 a.m., 12:00 p.m., 4:00 p.m., and 6:00 p.m. The medication was

	administered at those times on 1/1/22 and 1/2/22. During an interview on 1/3/22 at 4:25 p.m., Nurse Practitioner 2 indicated she had given verbal consent to change medication times, however, giving the Baclofen at 4:00 p.m. and 6:00 p.m. was not appropriate and would need to be re-evaluated for the administration time. On 1/4/22 at 10:35 a.m., the Director of Nursing provided a current copy of the document titled "Preparation and General Guidelines" dated 1/2017. It included, but was not limited to, "Policy...Medications are administered...in accordance with good nursing principles and practices...FIVE RIGHTS...right time, are applied for each medication being administered...."			

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