STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF FLOYDS KNOBS	3700 LAFAYETTE PKWY, FLOYDS KNOBS, , 47119

(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 IN00357753. Complaint IN00357753- Substantiated. State deficiencies related to the allegations are cited at R0036, R0090, and R0243. Survey date: July 14, 2021 Facility number: 012161 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 21, 2021.	R 0000		
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal	R 0036	The facility shall ensure the physician and family is notified of a resident’s fall, a significant decline in the resident 's	07/30/2021

	representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on interview and record review, the facility failed the ensure the physician and family were notified of a resident's (Resident B) fall, in a timely manner, for 1 of 3 residents reviewed for resident rights. Findings include: The clinical record for Resident B was reviewed on 7/14/21 at 12:25 p.m. Diagnoses included, but were not limited to, osteoarthritis and neuropathy. The nurse's note, dated 5/18/21 at 2:00 a.m., indicated the resident was found on the floor by her bed. The resident was assessed and assisted back to bed. The clinical record lacked documentation of the physician or family notification of the fall. During an interview on 7/14/21 at 1:46 p.m., Staff Member 2 indicated when a resident falls,		physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.in a timely manner. As all residents could be affected, the previous 30 days of nurse’s notes, shift-to-shift reports and incident reports will be reviewed to identify any incident and to confirm appropriate notifications were made in a timely manner. As a means to ensure ongoing compliance with ensuring the physician and family is notified of a resident’s fall, a significant decline in the resident 's physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment in a timely manner, nursing staff shall receive inservice training as to significant change in condition	

	the physician and family should be notified, by phone, at the time of the fall. On 7/14/21 at 1:05 p.m., the Director of Nursing provided a current copy of the document titled "Incident & Accident Report" and undated. It included, but was not limited to, "Purpose...To document all incidents and accident occurring involving residents...Procedure...Notify physician...Notify resident's responsible party...In all cased of an incident-accident, the following must be...documented...Time of all notifications...." This State tag relates to Complaint IN00357753 Based on interview and record review, the facility failed the ensure the physician and family were notified of a resident's (Resident B) fall, in a timely manner, for 1 of 3 residents reviewed for resident rights. Findings include: The clinical record for Resident B was reviewed on 7/14/21 at 12:25 p.m. Diagnoses included, but were not limited to, osteoarthritis and neuropathy. The nurse's note, dated 5/18/21 at 2:00 a.m., indicated the resident was found on the floor by her bed. The resident was		and necessary notifications to be made to physician and family. As a means of quality assurance, the Administrator/designee shall be responsible to review the shift-to-shift report and incident reports daily on scheduled days of work to confirm timely notifications to the physician and family. Should non-compliance be identified, corrective action shall be taken immediately.	

	assessed and assisted back to bed. The clinical record lacked documentation of the physician or family notification of the fall. During an interview on 7/14/21 at 1:46 p.m., Staff Member 2 indicated when a resident falls, the physician and family should be notified, by phone, at the time of the fall. On 7/14/21 at 1:05 p.m., the Director of Nursing provided a current copy of the document titled "Incident & Accident Report" and undated. It included, but was not limited to, "Purpose...To document all incidents and accident occurring involving residents...Procedure...Notify physician...Notify resident's responsible party...In all cased of an incident-accident, the following must be...documented...Time of all notifications...." This State tag relates to Complaint IN00357753			
R 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are	R 0090	The facility shall ensure a fall, which resulted in fracture, or other incident/occurrence as required by IDOH Reportable Unusual Occurrence Policy, shall be reported to the Indiana	07/30/2021

	not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and		Department of Health (IDOH) in a timely manner as per said policy. As all residents could be affected, the previous 30 days of nurse's notes, shift-to-shift reports and incident reports will be reviewed to identify any incident which would meet the criteria as reportable to the IDOH and the same shall be reported, if identified. As a means to ensure ongoing compliance with ensuring a fall, which resulted in fracture, or other incident/occurrence as required by IDOH Reportable Unusual Occurrence Policy shall be reported to the Indiana Department of Health (IDOH), as per said policy, the Administrator received one-to-one training regarding reporting requirements, conducted by the Regional Director. Additionally, the Director of Nursing shall receive training in the event he/she is responsible in the absence of the Administrator. As a means of quality assurance, the Regional Director shall review	

	(B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to ensure a fall, which resulted in fracture, was reported to the Indiana Department of Health (IDOH) for 1 of 1 residents reviewed for falls with significant injury. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/14/21 at 12:25 p.m. Diagnoses included, but were not limited to, osteoarthritis and neuropathy.		incidents/occurrences within the facility with the Administrator on an, at least, weekly basis to confirm required reporting occurs on a timely basis. Should non-compliance be identified, immediate corrective action shall be taken.	

	The nurse's note, dated 5/18/21 at 2:00 a.m., indicated the resident had fallen and was found on the floor by her bed. The resident was assessed and assisted back to bed. The nurse's note, dated 5/18/21 at 2:10 a.m., indicated the resident was resting in bed with her call light in reach. The nurse's note, dated 5/18/21 at 6:30 a.m., indicated the resident had pulled her call to request assistance to go to the bathroom and complained of pain to the left groin area. When the covers were pulled back, the resident's left foot was observed to be internally rotated and emergency services were called for transport to the hospital. The nurse's note, dated 5/18/21 at 12:50 p.m., indicated the hospital called to notify the facility that the resident had a fractured left hip. The facility could not provide an incident report of notification to the State of Resident B's fractured hip. During a telephone interview on 7/14/21 at 2:31 p.m., the Administrator indicated she was unaware that fractures had to be reported to the Indiana Department of Health. On 7/14/21 at 2:58 p.m.., the Director of Nursing provided a			

	current copy of the facility reporting policy titled "Indiana State Department of Health Division of Long Term Care" dated 7/15/15. It included, but was not limited to, "Title...Incident Reporting Policy...Residential Care Facilities...Types of incidents reportable under Residential State rules...Major Accidents...All fractures...." This State tag relates to Complaint IN00357753 Based on interview and record review, the facility failed to ensure a fall, which resulted in fracture, was reported to the Indiana Department of Health (IDOH) for 1 of 1 residents reviewed for falls with significant injury. (Resident B) Findings include: The clinical record for Resident B was reviewed on 7/14/21 at 12:25 p.m. Diagnoses included, but were not limited to, osteoarthritis and neuropathy. The nurse's note, dated 5/18/21 at 2:00 a.m., indicated the resident had fallen and was found on the floor by her bed. The resident was assessed and assisted back to bed.			

	The nurse's note, dated 5/18/21 at 2:10 a.m., indicated the resident was resting in bed with her call light in reach. The nurse's note, dated 5/18/21 at 6:30 a.m., indicated the resident had pulled her call to request assistance to go to the bathroom and complained of pain to the left groin area. When the covers were pulled back, the resident's left foot was observed to be internally rotated and emergency services were called for transport to the hospital. The nurse's note, dated 5/18/21 at 12:50 p.m., indicated the hospital called to notify the facility that the resident had a fractured left hip. The facility could not provide an incident report of notification to the State of Resident B's fractured hip. During a telephone interview on 7/14/21 at 2:31 p.m., the Administrator indicated she was unaware that fractures had to be reported to the Indiana Department of Health. On 7/14/21 at 2:58 p.m.., the Director of Nursing provided a current copy of the facility reporting policy titled "Indiana State Department of Health Division of Long Term Care" dated 7/15/15. It included, but was not limited to, "Title...Incident Reporting			

	Policy...Residential Care Facilities...Types of incidents reportable under Residential State rules...Major Accidents...All fractures...." This State tag relates to Complaint IN00357753			
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: (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 (Resident B) medication administration record accurately reflected the administration of a narcotic pain medication for 1 of 3 residents reviewed for medication administration. Findings include: The clinical record for Resident B was reviewed on 7/14/21 at	R 0243	The facility shall ensure residents' medication administration records are accurate and the individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (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. As all residents may be affected, the medication administration records of the last 30 days for all residents shall be reviewed to identify any omissions or discrepancies in administration of medication as per the physician's order. Should any such discrepancy be identified, immediate corrective action shall be taken.	07/30/2021

12:25 p.m. Diagnosis included, but was not limited to, osteoarthritis.

The physician's order, dated 1/19/21, indicated the resident was to receive Hydrocodone-APAP (narcotic pain medication) twice a day for osteoarthritis at 8:00 a.m. and 8:00 p.m.

Review of the February 2021 narcotic count record indicated the medication was signed out on the following dates and times:

- 2/02/21 at 8:00 a.m.

- 2/03/21 at 8:00 a.m.

- 2/04/21 at 8:00 p.m.

- 2/06/21 at 8:00 a.m. and 8:00 p.m.

- 2/07/21 at 8:00 a.m.

- 2/08/21 at 8:00 a.m. and 8:00 p.m.

- 2/09/21 at 8:00 p.m.

- 2/12/21 at 8:00 a.m. and 8:00 p.m.

- 2/16/21 at 8:00 a.m. and 8:00 p.m.

- 2/17/21 at 8:00 a.m.

- 2/20/21 at 8:00 a.m. and 8:00 p.m.

As means to ensure ongoing compliance with
accurately recording medication administration, all nursing staff shall receive
inservice training addressing documentation of the medication administration in the individual ' s medication and treatment records that indicate the: (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, as per the physician’s order.

As a means of quality assurance, the Director of Nursing
shall be responsible to monitor medication administration records on a weekly
basis for four weeks and monthly for a minimum of six months to confirm
accurate medication administration as per physician’s orders. Should an omission or discrepancy be identified, immediate corrective action shall be
taken.

- 2/21/21 at 8:00 a.m..

- 2/22/21 at 8:00 a.m.

- 2/26/21 at 8:00 a.m. and 8:00 p.m.

The February 2021 medication administration record lacked documentation of the administration of the narcotic pain medication.

Review of the March 2021 narcotic count record indicated the medication was signed out on the following dates and times:

- 3/01/21 at 8:00 p.m.

- 3/02/21 at 8:00 a.m. and 8:00 p.m.

- 3/03/21 at 8:00 a.m.

- 3/04/21 at 8:00 p.m.

- 3/05/21 at 8:00 p.m.

- 3/06/21 at 8:00 a.m. and 8:00 p.m.

- 3/07/21 at 8:00 a.m. and 8:00 p.m.

- 3/08/21 at 8:00 a.m.

- 3/12/21 at 8:00 a.m. and 8:00 p.m.

- 3/15/21 at 8:00 p.m.

- 3/16/21 at 8:00 a.m.

- 3/17/21 at 8:00 a.m.

- 3/20/21 at 8:00 p.m.

- 3/21/21 at 8:00 a.m. and 8:00 p.m.

- 3/26/21 at 8:00 a.m.

- 3/27/21 at 8:00 a.m.

- 3/28/21 at 8:00 a.m.

- 3/29/21 at 8:00 p.m.

- 3/30/21 at 8:00 a.m. and 8:00 p.m.

- 3/31/21 at 8:00 a.m.

The March 2021 medication administration record lacked documentation of the administration of the narcotic pain medication.

Review of the April 2021 narcotic count record indicated the medication was signed out on the following dates and times:

- 4/02/21 at 8:00 p.m.

- 4/03/21 at 8:00 a.m.

- 4/04/21 at 8:00 a.m.

- 4/05/21 at 8:00 a.m.

- 4/09/21 at 8:00 a.m. and 8:00 p.m.

- 4/12/21 at 8:00 p.m.

- 4/13/21 at 8:00 a.m. and 8:00 p.m.

- 4/14/21 at 8:00 a.m.

- 4/16/21 at 8:00 p.m.

- 4/19/21 at 8:00 a.m. and 8:00 p.m.

- 4/23/21 - 4/30/21 at 8:00 a.m. and 8:00 p.m.

The April 2021 medication administration record lacked documentation of the administration of the narcotic pain medication.

Review of the May 2021 narcotic count record indicated the medication was signed out on the following dates and times:

- 5/01/21 at 8:00 p.m.

- 5/03/21 at 8:00 a.m.

- 5/05/21 at 8:00 p.m.

- 5/07/21 at 8:00 a.m. and 8:00 p.m.

- 5/11/21 at 8:00 a.m. and 8:00 p.m.

- 5/12/21 at 8:00 a.m. and 8:00 p.m.

- 5/15/21 - 5/17/21 at 8:00 a.m. and 8:00 p.m.

The May 2021 medication administration record lacked

documentation of the administration of the narcotic pain medication.

During an interview on 7/14/21 at 1:05 p.m., the Director of Nursing indicated when a narcotic pain medication was given, staff should initial the medication administration record.

This State tag relates to Complaint IN00357753

Based on interview and record review, the facility failed to ensure a resident's (Resident B) medication administration record accurately reflected the administration of a narcotic pain medication for 1 of 3 residents reviewed for medication administration.

Findings include:

The clinical record for Resident B was reviewed on 7/14/21 at 12:25 p.m. Diagnosis included, but was not limited to, osteoarthritis.

The physician's order, dated 1/19/21, indicated the resident was to receive Hydrocodone-APAP (narcotic pain medication) twice a day for osteoarthritis at 8:00 a.m. and 8:00 p.m.

Review of the February 2021 narcotic count record indicated the medication was signed out

on the following dates and times:

- 2/02/21 at 8:00 a.m.

- 2/03/21 at 8:00 a.m.

- 2/04/21 at 8:00 p.m.

- 2/06/21 at 8:00 a.m. and 8:00 p.m.

- 2/07/21 at 8:00 a.m.

- 2/08/21 at 8:00 a.m. and 8:00 p.m.

- 2/09/21 at 8:00 p.m.

- 2/12/21 at 8:00 a.m. and 8:00 p.m.

- 2/16/21 at 8:00 a.m. and 8:00 p.m.

- 2/17/21 at 8:00 a.m.

- 2/20/21 at 8:00 a.m. and 8:00 p.m.

- 2/21/21 at 8:00 a.m..

- 2/22/21 at 8:00 a.m.

- 2/26/21 at 8:00 a.m. and 8:00 p.m.

The February 2021 medication administration record lacked documentation of the administration of the narcotic pain medication.

Review of the March 2021 narcotic count record indicated

	the medication was signed out on the following dates and times: - 3/01/21 at 8:00 p.m. - 3/02/21 at 8:00 a.m. and 8:00 p.m. - 3/03/21 at 8:00 a.m. - 3/04/21 at 8:00 p.m. - 3/05/21 at 8:00 p.m. - 3/06/21 at 8:00 a.m. and 8:00 p.m. - 3/07/21 at 8:00 a.m. and 8:00 p.m. - 3/08/21 at 8:00 a.m. - 3/12/21 at 8:00 a.m. and 8:00 p.m. - 3/15/21 at 8:00 p.m. - 3/16/21 at 8:00 a.m. - 3/17/21 at 8:00 a.m. - 3/20/21 at 8:00 p.m. - 3/21/21 at 8:00 a.m. and 8:00 p.m. - 3/26/21 at 8:00 a.m. - 3/27/21 at 8:00 a.m. - 3/28/21 at 8:00 a.m. - 3/29/21 at 8:00 p.m.			

- 3/30/21 at 8:00 a.m. and 8:00 p.m.

- 3/31/21 at 8:00 a.m.

The March 2021 medication administration record lacked documentation of the administration of the narcotic pain medication.

Review of the April 2021 narcotic count record indicated the medication was signed out on the following dates and times:

- 4/02/21 at 8:00 p.m.

- 4/03/21 at 8:00 a.m.

- 4/04/21 at 8:00 a.m.

- 4/05/21 at 8:00 a.m.

- 4/09/21 at 8:00 a.m. and 8:00 p.m.

- 4/12/21 at 8:00 p.m.

- 4/13/21 at 8:00 a.m. and 8:00 p.m.

- 4/14/21 at 8:00 a.m.

- 4/16/21 at 8:00 p.m.

- 4/19/21 at 8:00 a.m. and 8:00 p.m.

- 4/23/21 - 4/30/21 at 8:00 a.m. and 8:00 p.m.

The April 2021 medication administration record lacked

documentation of the administration of the narcotic pain medication.

Review of the May 2021 narcotic count record indicated the medication was signed out on the following dates and times:

- 5/01/21 at 8:00 p.m.

- 5/03/21 at 8:00 a.m.

- 5/05/21 at 8:00 p.m.

- 5/07/21 at 8:00 a.m. and 8:00 p.m.

- 5/11/21 at 8:00 a.m. and 8:00 p.m.

- 5/12/21 at 8:00 a.m. and 8:00 p.m.

- 5/15/21 - 5/17/21 at 8:00 a.m. and 8:00 p.m.

The May 2021 medication administration record lacked documentation of the administration of the narcotic pain medication.

During an interview on 7/14/21 at 1:05 p.m., the Director of Nursing indicated when a narcotic pain medication was given, staff should initial the medication administration record.

	This State tag relates to Complaint IN00357753			

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