STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VICTORIAN OF ZIONSVILLE	11755 N MICHIGAN RD, ZIONSVILLE, , 46077

(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 IN00361885. Complaint IN00361885 - Substantiated. State Residential Findings related to the allegations are cited at R0295. Survey date: September 20 and 21, 2021. Facility number: 012263 Residential Census: 68 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on October 4, 2021.	R 0000		
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and	R 0295	Please reference the enclosed “Plan of Correction for the September 20th and September 21st, 2021, complaint survey” I am respectfully	11/02/2021

nonprescription medications in their unit as long as they keep them secured from other residents.

Based on observation, interview, and record review, the facility failed to ensure residents who self-administered medication kept their medication locked up of 2 of 4 residents reviewed for secured medications (Resident C and P), failed to ensure medication bottles had complete labels for 1 of 4 residents review for self-administration (Resident C), failed to ensure narcotics were double locked for 1 of 4 residents reviewed for secured medications (Resident N), and failed to update a self-administration assessment accurately for a resident who no longer self-administer medications for 1 of 4 residents reviewed for self-administration (Resident M).

Findings include:

1. During an interview, on 9/20/21 at 2:00 p.m., Resident C indicated she did not lock her door during the day or night and did not have assistance from the facility for her medications. She kept them in a plastic bag on a living room chair and in her purse. She provided an example of her medication from the plastic bag, it was a small, enclosed packet from the pharmacy, dated 9/20/21 for

requesting paper compliance for this survey as deficiency was not part of initial complaint survey and was stated to be an observation and concern rather than formal deficiency.
Preparation and/or execution of this plan of correction does not constitute admission or agreement by the
provider of the true facts alleged or conclusion set forth in the statement of
deficiencies. This plan of correction is prepared and executed because it is required by the Federal and state laws.

R295

What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?

All
independent residents will be reassessed on medication self-administration to
ensure they are indeed independent with their medications, able to properly take
them, able to explain the use and all labels are on medication bottles. All independent residents will be educated on

	"MORNING." She did not take the medication this morning, she indicated she was one day behind but did not know why. The morning packet contained amlodipine 5 milligrams (mg) (lowers blood pressure), budesonide 3 mg (to treat Crohn's disease), calcium carbonate 1500 mg (supplement), centrum (supplement), metoprolol (antihypertensive), potassium chloride 20 milliequivalents (mEq) (supplement to treat low potassium), sertraline 50 mg (antidepressant), and Vitamin D3 (supplement). She indicated she should have taken them at 8:00 a.m. Resident C pulled three prescription bottles from her purse. The first bottle had different pills in it. There was no label, it was missing a resident name, name of medication, medication strength, physician's instructions, and expiration date. She indicated she took pills from that bottle as needed for diarrhea. The second bottle had a partially missing label, Resident C indicated she didn't know what it was, but took it for her anxiety. ZOLAM was the partial medication name. The third bottle was buspirone 5 mg (antianxiolytic), the physician's order indicated to take them twice a day. Resident C indicated she didn't know when she took them, maybe 8:00 a.m.		locking room doors at all times and if on any narcotics the medication is to be stored in a locked box. Resident that is currently no longer self-medicating assessment will be updated. <u>How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</u> All independent residents will be reassessed on self-administration and any new residents will be assessed before admission to ensure they can properly store medications, properly identify use of medications, and ingest them properly. If the resident is found to be no longer independent with self-medicating family will be notified as well as resident and medications will be removed from room for nursing staff to administer. <u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur?</u>	

and 5:00 p.m.

Resident C opened the plastic bag again and brought out two more small packets from the pharmacy for lunch and dinner too. One was dated 9/13/21, for "NOON." It contained budesonide 3 mg and Cranberry-Vitamin C 450-125 mg (supplement). The other one was dated 9/21/21, for "EVENING." It contained budesonide 3 mg, calcium carbonate 1500 mg, and metoprolol 25 mg.

On 9/20/21 at 3:15 p.m., Resident C's medical chart was reviewed. Her diagnoses included, but was not limited to, malignant neoplasm of part of left lung (lung cancer), acquired absence of left lung, osteoarthritis (degeneration of joints), age related osteoporosis (brittle bones), hypertension (high blood pressure), Crohn's disease (chronic inflammation of intestines), and hypokalemia (decreased blood potassium).

Her Service Plan was updated on 8/26/21. The cognitive evaluation indicated she had normal mental function. The medication management section indicated she was independent with medication management and the resident was able to identify and verbalize directions including route, time, dosage, and frequency for each

Once an
independent resident has any change of condition resident will be reassessed on
medication self-administration to ensure they can continue to self-medicate and
if unable the medications will be removed from room for nursing staff to
administer resident and family will be notified of changes and or any new
medication added to MAR the resident will be monitored for 30 days to ensure
resident is properly taking the medication and it is stored properly in room.

How the corrective actions will be monitored to ensure
the deficient practice will not recur, i.e., what quality assurance program
will be put into place?

All independent residents will be reassessed on
medication self-administration to ensure they are able to
self-medicate as well
as able to identify each medication and its reason on use if resident is unable
to self-medicate resident and family will be notified and nursing to administer
medications. Independent residents will be reeducated on how to properly store

	medication. 2. On 9/20/21 at 4:07 p.m., Resident P's record was reviewed. Her diagnoses included, but were not limited to, legally blind (central visual acuity of 20/200 or lower), macular degeneration (loss or distorted central vision), hypertension, congestive heart failure (weakness of the heart causing fluid build-up in the lungs and surrounding tissues), diabetes mellitus (disorder of blood sugar), hypercholesterolemia (high cholesterol), hyperlipidemia (increased fat concentration in the blood), and leg pain. Her Service Plan was updated on 5/21/21. The cognitive evaluation indicated she had normal mental function. The medication management section indicated she was independent with medication management. Her sensory limitations indicated she wears glasses at all times when out of bed. Regarding diabetic management, it indicated the resident is diabetic, but was independent with diabetic management and did not need an assist with subcutaneous injections, blood sugar testing and recording of blood sugars. During an interview, on 9/21/21 at 10:48 a.m., Resident P was observed leaving the elevator		medications and the importance of locking room doors at all times. All independent residents will be reassessed quarterly to ensure they are able to pass the self-administration test and take their medication safely. This will be completed by 11/2/2021	

and opening her unlocked door. She indicated she had been to the dentist and usually kept her door unlocked. She kept her insulin in the refrigerator. Levemir and Novolog, and the remaining medications in a closed, unlocked bedroom drawer. She had lisinopril (for high blood pressure), aspirin (low dose blood thinner), cephalexin (antibiotic to prevent urinary tract infections), Vitamin B12 (supplement), Vitamin D3 (supplement), Tylenol (pain relief), and clindamycin (antibiotic she uses before the dentist visits).

During an interview, on 9/21/21 at 11:45 a.m., Resident P indicated she was legally blind. She used her glasses and different strength magnifying glasses, 6X, 8X, and 10X, to see. With her NovoLog, she counted the clicks on the pen and verified it with the magnifying glass. With the Levemir, she turned it, and verified it with the magnifier.

3. During an interview, on 9/21/21 at 10:37 a.m., Resident N indicated she locked up her apartment when she left. She did have narcotic pain medication, hydrocodone/apap tablets 5-325 mg to take as needed. They were not locked up inside the apartment. An observation inside her unlocked kitchen cabinet showed

approximately 18 bottles of prescriptions and over the counter medications. There was a disposable plastic cup with a loose pill at the bottom and a stapled plastic container with medications inside of it. She indicated she did not take the medications inside the stapled plastic container. Her son was her caregiver who assisted her with her medication management by putting her medication into weekly containers.

On 9/20/21 at 3:55 p.m., Resident N's record was reviewed. Her diagnoses included, but were not limited to, cardiac megaly (enlarged heart), chronic pain, hypertension, and history of recurrent urinary tract infections.

Her Service Plan was updated on 5/24/21. The cognitive evaluation indicated she had normal mental function. The medication management section indicated she was independent with medication management with no caregiver who assisted her with her medication management.

4. On 9/20/21 at 3:40 p.m., Resident M's record was reviewed. Her diagnoses included, but were not limited to, atrial fibrillation (flutter of the heart), hypertension anxiety, hypothyroidism (decreased

function of the thyroid), TIA (stroke), macular degeneration depression, GERD (gastro-esophageal reflux), and osteoarthritis.

Her Service Plan was updated on 5/24/21. The cognitive evaluation indicated she had normal mental function. The medication management section indicated she was independent with medication management.

During an interview, on 9/21/21 at 10:26 a.m., Resident M indicated she had no medications in her room. She started out with providing and administering her own medications but has not done so for a long time, probably prior to the pandemic isolation the resident experienced. The facility provided and administered all her medications.

During an interview, on 9/21/21 at 12:20 p.m., the Executive Director (ED) indicated if a resident's pharmaceutical small packet indicated, 9/13/21 Morning, the resident should have taken it on that date and at that time. All prescription bottles with prescription medications inside should have had a complete pharmacy label on it. All residents who self-administer medications should kept their doors locked, and if they had narcotics in their room, they

should be locked up inside the room as well.

A current policy, titled, "Assistance with Medication," dated 9/7/11, was provided by the ED, on 9/21/21 12;15 p.m. A review of the policy indicated, " ...All residents will be assessed in order to evaluate the need for mediation assistance ...The amount and type of assistance needed will be defined in the resident's assistance/service plan...."

A current policy, titled, "Self-Administration of Medications," dated 9/27/11, was provided by the ED, on 9/21/21 12;15 p.m. A review of the policy indicated, " ...Residents are expected to manage their own medications if they are capable as determined by the Self Administering Checklist...."

This State Residential Finding relates to Complaint IN00361885.

Based on observation, interview, and record review, the facility failed to ensure residents who self-administered medication kept their medication locked up of 2 of 4 residents reviewed for secured medications (Resident C and P), failed to ensure medication bottles had complete labels for 1 of 4 residents review for

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This State Residential Finding relates to Complaint IN00361885.

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