STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK PLACE II, LLC	4411 PARK PLACE DR, FORT WAYNE, , 46845

(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 IN00363455. Complaint IN00363455-Substantiated. State deficiencies related to the allegations are cited at R0241. Survey date: September 30, 2021 Facility number: 012582 Residential Census: 146 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 30, 2021	R 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests Desk Review in lieu a Post Survey Review.	
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as	R 0241	R-241	11/14/2021

	ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on record review and interview, the facility failed to ensure nursing staff administered insulin to the correct resident per physician orders for 1 of 3 records reviewed (Resident D). This resulted in Resident D being admitted to the hospital. Findings include The record for Resident D was reviewed on 9/30/21. Diagnoses for Resident D included, but were not limited to, hypertension (high blood pressure), chronic atrial fibrillation, osteoarthritis, muscle weakness, and falling. The physician orders did not indicate that Resident D was diabetic, and therefore did not order insulin. The record observation note dated 9/23/21 at 5:32 P.M. indicated Employee 2 administered 90 units of Humalog insulin to Resident D. The resident was admitted to the hospital on 9/23/21 and returned 9/25/21 with no new orders. During an interview on 9/30/21 at 9:45 A.M., the Executive		With regards to finding R241 Health Services Park Place Senior Living will; ***What corrective actions will be accomplished for those residents found to have been affected by the finding:*** Licensed nurse responsible for medication error was immediately re-educated on rights of medication administration. ***How will you identify other residents having the potential to be affected by the same finding and what corrective action will be taken:*** All residents had the potential to be affected. No other residents were adversely affected.	

	Director (ED) indicated the nurse that gave the insulin had been ill since the incident happened and had not yet returned to work. She had not signed the incident report. The ED indicated there were 2 residents on the memory care unit with the same first names [Residents C and D]. She indicated the nurse training Employee 2 had told her Resident D, who was to receive the insulin, was in the green shirt in the wheelchair. Resident C was also wearing green that day and was right beside Resident D sitting in a wheelchair. During interview on 9/30/21 at 10:18 A.M., Employee 4 indicated she always checked the medication rights, and since she was new, she could also verify with other staff if she was not sure of the resident identification. During an interview on 9/30/21 at 10:25 A.M., Employee 3 indicated that on the memory care unit, some residents wou;ld not be able to tell their names and date of birth, but there were pictures on the electronic records to help with identification. The facility policy titled "Medication Incident," no number, indicated "The community/facility is responsible		***What measures will be put in place or what systemic changes the facility will make to ensure that the deficient practice does not recur:*** All nursing staff will be in serviced on rights of medication administration with an emphasis on correctly identifying resident prior to administering medications. ***How the corrective action(s) will be monitored to ensure the finding will not recur:*** Wellness Director or her designee will audit medication passes to ensure compliance with the six rights of medication administration 2x per week for one month, weekly for three	

	for ensuring that each resident receives his or her medication according tot he doctor's orders. A medication incident occurs when a resident receives the wrong medication ...." The facility policy titled "Six Rights Of Medication Administration," dated 2011, indicated "When you are giving medication, regardless of the type of medication, you must always follow the six rights. Each time you administer a medication, you need to be sure to have the: 1. Right individual 2.. Right medication 3. Right dose 4. Right time 5. Right route 6. Right documentation ... Each time that you give a mediating, yo also need to remember to do the "Three Checks". This means that you are going to do a "triple-check" to make sure that the six rights are present each time that you give a medications. ...." This State Residential finding relates to Complaint IN00363455. 16.2-5-4(c)(1) Based on record review and interview, the facility failed to ensure nursing staff administered insulin to the correct resident per physician orders for 1 of 3 records reviewed (Resident D). This resulted in Resident D being		months and randomly thereafter. ***By what date the systemic changes will be completed:*** 11/14/21	

admitted to the hospital.

Findings include

The record for Resident D was reviewed on 9/30/21. Diagnoses for Resident D included, but were not limited to, hypertension (high blood pressure), chronic atrial fibrillation, osteoarthritis, muscle weakness, and falling. The physician orders did not indicate that Resident D was diabetic, and therefore did not order insulin. The record observation note dated 9/23/21 at 5:32 P.M. indicated Employee 2 administered 90 units of Humalog insulin to Resident D. The resident was admitted to the hospital on 9/23/21 and returned 9/25/21 with no new orders.

During an interview on 9/30/21 at 9:45 A.M., the Executive Director (ED) indicated the nurse that gave the insulin had been ill since the incident happened and had not yet returned to work. She had not signed the incident report. The ED indicated there were 2 residents on the memory care unit with the same first names [Residents C and D]. She indicated the nurse training Employee 2 had told her Resident D, who was to receive the insulin, was in the green shirt in the wheelchair. Resident C was also wearing green that day and was right beside

Resident D sitting in a wheelchair.

During interview on 9/30/21 at 10:18 A.M., Employee 4 indicated she always checked the medication rights, and since she was new, she could also verify with other staff if she was not sure of the resident identification.

During an interview on 9/30/21 at 10:25 A.M., Employee 3 indicated that on the memory care unit, some residents wou;ld not be able to tell their names and date of birth, but there were pictures on the electronic records to help with identification.

The facility policy titled "Medication Incident," no number, indicated "The community/facility is responsible for ensuring that each resident receives his or her medication according tot he doctor's orders. A medication incident occurs when a resident receives the wrong medication ...."

The facility policy titled "Six Rights Of Medication Administration," dated 2011, indicated "When you are giving medication, regardless of the type of medication, you must always follow the six rights. Each time you administer a medication, you need to be sure to have the: 1. Right individual

	2.. Right medication 3. Right dose 4. Right time 5. Right route 6. Right documentation ... Each time that you give a mediating, yo also need to remember to do the "Three Checks". This means that you are going to do a "triple-check" to make sure that the six rights are present each time that you give a medications. ...." This State Residential finding relates to Complaint IN00363455. 16.2-5-4(c)(1)			

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