

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/02/2022	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK OF BLOOMINGTON MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3203 MOORES PIKE ROAD, BLOOMINGTON, , 47401					
(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 IN00388860. Complaint IN00388860 - Substantiated. State deficiencies related to the allegations are cited at R64. Survey dates: September 1 and 2, 2022 Facility number: 012706 Residential Census: 35 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed September 9, 2022.	R 0000					
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	R 0064	-What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: all residents, including those residents found to have			10/23/2022	

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 record review and interview, the facility failed to exercise reasonable care for the protection of residents property from loss and theft for 2 of 5 residents reviewed for misappropriation of property. (Residents D, Resident E)

Finding includes:

During a review of the facility self reported incident, on date and time, the facility found the medication count was incorrect for Resident D. The investigation found that Resident F's Norco 5 mg (milligram)/325 mg was 23 tablets off. Resident D's Hydrocodone 5 mg/325 mg had been replaced with Tylenol. During a review of all resident's narcotics, the NP (Nurse Practitioner) observed that Resident B and Resident E's morphine appeared diluted.

During an interview with the NP on 9/1/22 at 2:00 p.m., she indicated she ordered another bottle of morphine, went and picked it up from the pharmacy, and compared the color of the medication in the bottles and found them to be 2 different

been affected y the deficient practice, will have their medications more frequently. Executive Director or designated person will continue to do medication audits with DON on at least a weekly basis for 2 months followed by a monthly medication audit for 2 months. Each affected resident's primary medical provider will be notified of any possible medication errors including those resulting from not receiving prescribed medication.

-How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: all residents, including those residents found to have been affected by the deficient practice, will have their medications monitored more frequently. Executive Director or designated person will continue to do medication audits with DON on at least a weekly basis for 2 months followed by a monthly medication audit for 2 months. Each affected resident's primary medical provider will be notified of any possible medication errors including those resulting from not receiving prescribed medication.

-What measures will be put into place or what systemic changes

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colors, appearing diluted.

During an interview with the ED (Executive Director), 9/1/22 at 2:00 p.m., she indicated she tried to contact the agency QMA (Qualified Medication Assistant) to come in and submit to a drug screen. The agency QMA would not return messages or calls from the ED. The ED indicated that while all the narcotic counts appeared to be correct, upon further inspection the morphine had been diluted and the pills had been replaced with Tylenol.

On 9/1/22 at 12:00 p.m., the ED provided the facility policy for Medication Administration Policy and Procedures updated February 24, 2022, and indicated this policy was the one the facility followed. It indicated "a licensed nurse or other designated staff ... and witness should document via a count-down sheet when a narcotic is counted and verified.

This State tag relates to Complaint IN00388860.

Based on record review and interview, the facility failed to exercise reasonable care for the protection of residents property from loss and theft for 2 of 5 residents reviewed for misappropriation of property. (Residents D, Resident E)

Finding includes:

the facility will make to ensure that the deficient practice does not recur: ongoing nursing in-services will occur to inform all staff of our medication policies and procedures. Executive Director, Nurse Practitioner, DON & support will work hand-in-hand to ensure medication counts, audits and education are continual.

-How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Corrective actions will be monitored using the attached spreadsheet that shows that medication audits have been completed on the set forth schedule. Systematically, this will include any QMA/Nurse, DON, Executive Director and clinical support at the community.

-By what date the systemic changes will be completed: The audit tools will remain in place for at least 4 months. Weekly for 2 months and monthly for 2 additional months. If discrepancies are found, additional education will be provided.

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During an interview with the NP on 9/1/22 at 2:00 p.m., she indicated she ordered another bottle of morphine, went and picked it up from the pharmacy, and compared the color of the medication in the bottles and found them to be 2 different colors, appearing diluted.

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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