

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/09/2024	
NAME OF PROVIDER OR SUPPLIER ASTER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 741 PARK EAST BLVD, LAFAYETTE, , 47905					
(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 IN00443540. Complaint IN00443540- State deficiencies related to the allegations are cited at R0296. Survey dates: October 8 and 9, 2024. Facility number: 013045 Residential Census: 104 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review was completed on October 16, 2024.	R 0000					
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	R 0296	Corrections from previous timeframes cannot be made. Residents B, C, and D were evaluated by nursing on 10/09/2024 to ensure no adverse reactions had occurred. No abnormal			11/09/2024	

shall provide for ongoing training to ensure competence of medication staff.

Based on interview and record review, the facility failed to ensure medications were given as ordered by the resident's physician for 3 of 3 residents reviewed for administration of medications. (Residents B, C and D)

Findings include:

1. The clinical record for Resident B was reviewed on 10/8/24 at 4:50 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperlipidemia, hypokalemia, depression, and anxiety.

The Medication Administration Record (MAR) indicated Resident B was to receive 5 units of Fiasp (a rapid-acting insulin) 100 unit/ml subcutaneously (under the skin) 3 times a day with meals. The medication was not documented as given on 7/13/24 at 12:00 p.m. and 4:00 p.m., on 7/14/24 at 12:00 p.m. and 4:00 p.m., and on 9/15/24 at 12:00 p.m.

The MAR indicated Resident B was to receive Fiasp 100 unit/ml subcutaneously per the physician ordered sliding scale 3 times daily after the blood sugar reading was obtained. On

findings identified during the assessment. [Staff member 2 provided disciplinary action and education.](#) Current nurses and QMAs were re-educated beginning 10/09/2024 prior to next shift worked by the Executive Director (ED) and Director of Nursing (DON) regarding proper medication administration and documentation (Attachments 1 and 2).

On 10/10/2024, DON and designee conducted a medication administration audit of current residents to ensure residents are free from medication omissions without supportive documentation with no additional findings noted. By 10/25/2024, ED and designee will conduct an interview of cognitively intact residents to ensure residents are free from medication administration concerns. Results will be reviewed at WeCare Meeting and appropriate interventions will be implemented at time of finding as necessary.

Current nurses and QMAs were re-educated beginning 10/09/2024 but, prior to the next

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OMB NO. 0938-0391

7/27/24, zero units were given, and 4 units should have been given. On 9/29/24, zero units were given, and 4 units should have been given. On 10/5/24 at 4:00 p.m., 2 units were given, and 3 units should have been given.

During an interview, on 10/8/24 at 2:35 p.m., Resident B indicated she had trouble with a weekend staff member (staff member 2) who did not give her the correct insulin for her blood sugar levels. She indicated it was an ongoing issue and she had reported this to the management team.

2. The clinical record for Resident C was reviewed on 10/8/24 at 4:30 p.m. The diagnoses included, but were not limited to, kidney and liver transplant, depression, and type 2 diabetes mellitus.

The MAR indicated Resident C was to receive 5 units of Fiasp 100 unit/ml subcutaneously 3 times a day with meals. The medication was not documented as given on 9/7/24 at 6:00 p.m.

3. The clinical record for Resident D was reviewed on 10/9/24 at 1:50 p.m. The diagnoses included, but were not limited to, vascular dementia, hypertension, and type 2 diabetes mellitus.

The MAR indicated Resident D

shift worked; by the Executive Director (ED) and Director of Nursing (DON) regarding proper medication administration and documentation. Resident B's care plan was updated on 10/16/2024 by ED to include staff preferences. Staff member 2 provided disciplinary action and education.

DON and designee will audit all medication administration records. (Monday-Friday) for four (4) weeks; two times (2x) a week for the following four (4) weeks; once a week (1x) for the following four (4) weeks; and two times (2x) per month for the following eight (8) weeks. The results of these audits will be reviewed by the facility Quality Assurance Performance Improvement (QAPI) committee for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.

was to receive Novolog (a rapid-acting insulin) subcutaneously per the physician ordered sliding scale after the blood sugar check 3 times a day after meals. The medication was not documented as given on 9/22/24 at 7:00 a.m. and 11:00 a.m. The documentation indicated no test strips. On 9/28/24 at 7:00 a.m., the medication was documented as not given.

During an interview, on 10/9/24 at 4:15 p.m., staff member 2 indicated he gave the medications but did not document the administration. He did not notify the physician of the medication omissions due to missing testing equipment or resident refusal. The facility policy indicated he only had to call after 3 omissions. He utilized good nursing practice by observing the resident when the medication was not given.

During an interview, on 10/9/24 at 12:50 p.m., the Director of Nursing indicated if the medication had been given the documentation should have been completed. She indicated good nursing practice would have been to notify the physician when a medication was not given.

A current facility policy, titled "Resident Refusal of Medications/Treatments," with

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an effective date of 11/15 and received from the Executive Director on 10/9/24 at 3:10 p.m., indicated "...Medication and treatments will be offered to the residents as prescribed by the physician...If a resident refuses administration of a medication or treatment for three consecutive days, the physician and family will be contacted and made aware of the refusals. 6. If medication that is being refused will potentially place the resident in harm's way, timely communication to physician/family is to occur...."

This citation relates to Complaint IN00443540.

Based on interview and record review, the facility failed to ensure medications were given as ordered by the resident's physician for 3 of 3 residents reviewed for administration of medications. (Residents B, C and D)

Findings include:

1. The clinical record for Resident B was reviewed on 10/8/24 at 4:50 p.m. The diagnoses included, but were not limited to, type 2 diabetes mellitus, hyperlipidemia, hypokalemia, depression, and anxiety.

The Medication Administration Record (MAR) indicated Resident B was to receive 5

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units of Fiasp (a rapid-acting insulin) 100 unit/ml subcutaneously (under the skin) 3 times a day with meals. The medication was not documented as given on 7/13/24 at 12:00 p.m. and 4:00 p.m., on 7/14/24 at 12:00 p.m. and 4:00 p.m., and on 9/15/24 at 12:00 p.m.

The MAR indicated Resident B was to receive Fiasp 100 unit/ml subcutaneously per the physician ordered sliding scale 3 times daily after the blood sugar reading was obtained. On 7/27/24, zero units were given, and 4 units should have been given. On 9/29/24, zero units were given, and 4 units should have been given. On 10/5/24 at 4:00 p.m., 2 units were given, and 3 units should have been given.

During an interview, on 10/8/24 at 2:35 p.m., Resident B indicated she had trouble with a weekend staff member (staff member 2) who did not give her the correct insulin for her blood sugar levels. She indicated it was an ongoing issue and she had reported this to the management team.

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2. The clinical record for Resident C was reviewed on 10/8/24 at 4:30 p.m. The diagnoses included, but were not limited to, kidney and liver transplant, depression, and type 2 diabetes mellitus.

The MAR indicated Resident C was to receive 5 units of Fiasp 100 unit/ml subcutaneously 3 times a day with meals. The medication was not documented as given on 9/7/24 at 6:00 p.m.

3. The clinical record for Resident D was reviewed on 10/9/24 at 1:50 p.m. The diagnoses included, but were not limited to, vascular dementia, hypertension, and type 2 diabetes mellitus.

The MAR indicated Resident D was to receive Novolog (a rapid-acting insulin) subcutaneously per the physician ordered sliding scale after the blood sugar check 3 times a day after meals. The medication was not documented as given on 9/22/24 at 7:00 a.m. and 11:00 a.m. The documentation indicated no test strips. On 9/28/24 at 7:00 a.m., the medication was documented as not given.

During an interview, on 10/9/24 at 4:15 p.m., staff member 2 indicated he gave the medications but did not document the administration. He

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did not notify the physician of the medication omissions due to missing testing equipment or resident refusal. The facility policy indicated he only had to call after 3 omissions. He utilized good nursing practice by observing the resident when the medication was not given.

During an interview, on 10/9/24 at 12:50 p.m., the Director of Nursing indicated if the medication had been given the documentation should have been completed. She indicated good nursing practice would have been to notify the physician when a medication was not given.

A current facility policy, titled "Resident Refusal of Medications/Treatments," with an effective date of 11/15 and received from the Executive Director on 10/9/24 at 3:10 p.m., indicated "...Medication and treatments will be offered to the residents as prescribed by the physician...If a resident refuses administration of a medication or treatment for three consecutive days, the physician and family will be contacted and made aware of the refusals. 6. If medication that is being refused will potentially place the resident in harm's way, timely communication to physician/family is to occur...."

This citation relates to

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	Complaint IN00443540.			
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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.)				
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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