

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 09/18/2024
NAME OF PROVIDER OR SUPPLIER SUGAR FORK CROSSING		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 EAST 67TH STREET, ANDERSON, , 46013			
(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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00441028. Complaint IN00441028 - State deficiencies related to the allegations are cited at R0064. Survey dates: September 16, 17, and 18, 2024 Facility number: 014080 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 23, 2024.	R 0000	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance.		
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection	R 0064	1. The community has completed a comprehensive investigation of the reported incident, inclusive of alerting local law	10/30/2024	

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of residents ' property from loss 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 ensure a cognitively impaired resident was free from misappropriation for 1 of 3 reviewed for misappropriation. (Resident B)

Finding includes:

A 8/14/24, facility self -reported incident indicated the following: "Brief Description of Incident": A report was made to the Director of Health and Wellness by CNA 6 and HHA 7 that a previous employee, CNA 8, had made purchases using Resident B's online retailer account. The immediate actions taken included inquiring with Resident B's online retailer account and confirming any purchases. The Director of Health and Wellness advised the Administrator of the incident at this time. CNA 6 and HHA 7 provided written statements. The Administrator contacted Resident B's family and the local police. Preventative measures indicated the facility would education the staff on resident rights and complete an in-service. A follow-up letter was

enforcement. After receiving notice from local law enforcement that criminal charges would be sought, the community notified the Indiana Licensing Agency as to the former Team Member's involvement.

2. The resident's Responsible Party has filed a fraud claim with Amazon for reimbursement of the unauthorized purchases.

3. The community has conducted a review of current Team Member files to ensure that results of a criminal background screen prior to their date of hire are on file. Future Team Members shall have a criminal background screen completed prior to their date of hire, and results shall be maintained within their personnel file.

4. The community's Executive Director, or their designee, shall complete a review of Resident Rights with current community Team Members. Completion of such review is anticipated no

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sent to family members of the community.

Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnoses included congestive heart failure, atrial fibrillation, and polyneuropathy.

A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive impairment.

An 8/14/24 progress note indicated a report was made about a prior employee using Resident B's online retailer account to make purchases. An investigation was started, family notified, and a police report filed.

A 3/13/24, "Resident Rights" document was signed and acknowledged by Resident B.

A review of the facility investigation file, provided by the Administrator on 9/17/24 at 10:43 a.m. included the following:

An 8/14/24, written statement from CNA 6 indicated she was told by a co-worker, HHA 7, that a previous employee had ordered off Resident B's online retailer account. CNA 6 checked Resident B's cellular device and saw the charges and delivery address for the previous employee.

later than October 30, 2024, and shall be evidenced by Inservice Attendance Logs, to be maintained with the community's training files.

5. New community Team Members shall be oriented to Resident Rights within their new hire onboarding process. Completion of orientation shall be evidenced by Inservice Attendance Logs, to be maintained with the community's training files.

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An 8/14/24, written statement from HHA 7 indicated she was told by a co-worker that a former co-worker was ordering stuff off a resident's cellular phone and posting pictures on social media.

Screen shots from Resident B's cellular phone with "Order Details" from her online retailer account, dated 7/6/24 indicated a shipping address listed was different from the Resident B's address. The address listed was connected to CNA 8, the former employee. The merchandise total was \$357.74.

A social media picture, dated 7/9/24, of CNA 8 with one of the possible items purchased using Resident B's online retailer account.

An 8/16/24, letter to the community family and friends advising of the isolated incident.

A handwritten timeline, written by the Administrator, indicated the steps taken in the investigation.

A review of CNA 8's employee file, on 9/17/24 at 4:41 p.m., indicated his hire date was 5/28/24 and termination date as 7/12/24.

A 7/11/24, "Employee Termination Notification" document indicated CNA 8's last worked day was 7/9/24 and

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the reason for termination was No Call/No Show for scheduled shifts.

A 5/22/24, "Resident Rights" document, signed and acknowledged by CNA 8.

A 5/22/24, "Abuse and Neglect Reporting" document, signed and acknowledged by CNA 8.

A 9/18/24, transcript from a workforce education database indicated CNA 8 completed the following abuse and dementia trainings: "Dementia care: Normal Aging vs Alzheimer's/Dementia", completed 5/28/24. "Alzheimer's Disease and Related Disorders: ADL Care", completed 6/3/24. "Alzheimer's Disease and Related Disorders: ADL's and Behaviors", completed 6/3/24. "Alzheimer's Disease and Related Disorders: Communication Needs", completed 6/3/24. "Alzheimer's Disease and Related Disorders: Recreational Activities", completed 6/3/24. "Alzheimer's Disease and Related Disorders: The Environment", completed 6/3/24. "Preventing, Recognizing, and Reporting Abuse", completed 5/30/24. "Abuse, Neglect, and Exploitation", completed 5/28/24.

During an interview, on 9/17/24 at 2:45 p.m., Resident B's family

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indicated the facility had contacted them about a former staff member using the online retailer account of their loved one for personal purchases. The family indicated the facility had contacted the police. The facility was investigating the incident as well. The family planned to look at additional financial records to ensure all fraudulent activity was discovered. The family was concerned since Resident B had dementia and would be extremely upset if she knew the extent of the situation. The family indicated they had been told this staff member was working at another facility.

During an interview on 9/17/24 at 3:31 p.m., CNA 6 indicated she was told by HHA 7 that an ex-employee had been ordering items online from a resident's account. She went and checked the resident's phone and found the charges with a different address for the delivery. She immediately told the Director of Health and Wellness. She was not sure if the former employee was employed by the facility at that time. CNA 6 wrote a statement and spoke with a detective a few days ago.

During an interview, on 9/17/24 at 4:01 p.m., the Administrator indicated the incident was fairly cut and dry. There was a clear path. The address matched the former employees address. She

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felt it was easy to ascertain the validity of the accusation. She had not reported the former employee to the license board at this time, since the police investigation was still ongoing. CNA 8 was terminated for No Call/No Show of scheduled shifts in July 2024.

An undated, current facility policy, titled, " Resident Rights", provided by the Director of Heath and Wellness, on 9/18/24 at 9:00 a.m., indicated the following: "... 36. The right to have the Community exercise reasonable care for the protection of your property from loss or theft."

This citation relates to Complaint IN00441028.

Based on record review and interview, the facility failed to ensure a cognitively impaired resident was free from misappropriation for 1 of 3 reviewed for misappropriation. (Resident B)

Finding includes:

A 8/14/24, facility self -reported incident indicated the following: "Brief Description of Incident": A report was made to the Director of Health and Wellness by CNA 6 and HHA 7 that a previous employee, CNA 8, had made purchases using Resident B's online retailer account. The immediate actions taken

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Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnoses included congestive heart failure, atrial fibrillation, and polyneuropathy.

A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive impairment.

An 8/14/24 progress note indicated a report was made about a prior employee using Resident B's online retailer account to make purchases. An investigation was started, family notified, and a police report filed.

A 3/13/24, "Resident Rights" document was signed and acknowledged by Resident B.

A review of the facility investigation file, provided by

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the Administrator on 9/17/24 at 10:43 a.m. included the following:

An 8/14/24, written statement from CNA 6 indicated she was told by a co-worker, HHA 7, that a previous employee had ordered off Resident B's online retailer account. CNA 6 checked Resident B's cellular device and saw the charges and delivery address for the previous employee.

An 8/14/24, written statement from HHA 7 indicated she was told by a co-worker that a former co-worker was ordering stuff off a resident's cellular phone and posting pictures on social media.

Screen shots from Resident B's cellular phone with "Order Details" from her online retailer account, dated 7/6/24 indicated a shipping address listed was different from the Resident B's address. The address listed was connected to CNA 8, the former employee. The merchandise total was \$357.74.

A social media picture, dated 7/9/24, of CNA 8 with one of the possible items purchased using Resident B's online retailer account.

An 8/16/24, letter to the community family and friends advising of the isolated incident.

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A handwritten timeline, written by the Administrator, indicated the steps taken in the investigation.

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A 7/11/24, "Employee Termination Notification" document indicated CNA 8's last worked day was 7/9/24 and the reason for termination was No Call/No Show for scheduled shifts.

A 5/22/24, "Resident Rights" document, signed and acknowledged by CNA 8.

A 5/22/24, "Abuse and Neglect Reporting" document, signed and acknowledged by CNA 8.

A 9/18/24, transcript from a workforce education database indicated CNA 8 completed the following abuse and dementia trainings: "Dementia care: Normal Aging vs Alzheimer's/Dementia", completed 5/28/24. "Alzheimer's Disease and Related Disorders: ADL Care", completed 6/3/24. "Alzheimer's Disease and Related Disorders: ADL's and Behaviors", completed 6/3/24. "Alzheimer's Disease and Related Disorders: Communication Needs", completed 6/3/24. "Alzheimer's

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Disease and Related Disorders: Recreational Activities", completed 6/3/24. "Alzheimer's Disease and Related Disorders: The Environment", completed 6/3/24. "Preventing, Recognizing, and Reporting Abuse", completed 5/30/24. "Abuse, Neglect, and Exploitation", completed 5/28/24.

During an interview, on 9/17/24 at 2:45 p.m., Resident B's family indicated the facility had contacted them about a former staff member using the online retailer account of their loved one for personal purchases. The family indicated the facility had contacted the police. The facility was investigating the incident as well. The family planned to look at additional financial records to ensure all fraudulent activity was discovered. The family was concerned since Resident B had dementia and would be extremely upset if she knew the extent of the situation. The family indicated they had been told this staff member was working at another facility.

During an interview on 9/17/24 at 3:31 p.m., CNA 6 indicated she was told by HHA 7 that an ex-employee had been ordering items online from a resident's account. She went and checked the resident's phone and found the charges with a different address for the delivery. She

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immediately told the Director of Health and Wellness. She was not sure if the former employee was employed by the facility at that time. CNA 6 wrote a statement and spoke with a detective a few days ago.

During an interview, on 9/17/24 at 4:01 p.m., the Administrator indicated the incident was fairly cut and dry. There was a clear path. The address matched the former employees address. She felt it was easy to ascertain the validity of the accusation. She had not reported the former employee to the license board at this time, since the police investigation was still ongoing. CNA 8 was terminated for No Call/No Show of scheduled shifts in July 2024.

An undated, current facility policy, titled, " Resident Rights", provided by the Director of Heath and Wellness, on 9/18/24 at 9:00 a.m., indicated the following: "... 36. The right to have the Community exercise reasonable care for the protection of your property from loss or theft."

This citation relates to Complaint IN00441028.

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the	R 0216	1. The Director of Health and Wellness and/or designee will be re-educated by our Regional Director of Health	10/05/2024
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evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure a medication self-administration assessment was completed prior to a resident self-administering medications for 1 of 3 residents reviewed for medication self-administration. (Resident C) Finding includes: Resident C's clinical record was reviewed on 9/16/24 at 2:04 p.m. The resident admitted to the facility on 7/30/24. Diagnoses included essential hypertension, unspecified depression, and anxiety. A provider's order indicated the	and Wellness on the process for admission of a resident who is seeking to self-administer medication by 10.5.2024 2. The Health and Wellness Director and/or designee will complete the Self Administer Medication Assessment prior to move in and review with the administrator for compliance prior to any resident approved admission. 3. The Director of Health and Wellness and/or Designee shall complete a self-med assessments on each resident who is self-medicating and can be found in the resident's wellness file. 4. Audit measures going forward- Director of Health and Wellness and/or designee audit 2 charts/ month for 6 months and report results to ED. If there are no discrepancies observed within that 6-month period, regular audits will discontinue, and sporadic audits going forward.	
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resident may administer, store, and coordinate all medications without staff assistance.

Current physician orders, dated 7/5/24, included the following: amlodipine (blood pressure) 10 milligrams (mg) - give 1 tablet by mouth daily, losartan (blood pressure) 100 mg - give 1 tablet by mouth daily, bisoprolol (blood pressure) 10 mg - give 1 tablet by mouth daily, and Effexor XR (depression) 150 mg - give 1 capsule by mouth daily.

The clinical record lacked an assessment for self-administration of medications prior to the resident self-administering her medications.

During an interview on 9/18/24 at 10:17 a.m., Resident C indicated she had been on the same medications prior to admission to the facility. She had been self-administering her own medications since she arrived at the facility on 7/30/24. The facility never administered her medications.

During an interview on 9/18/24 at 10:50 p.m., the Administrator indicated the resident admitted to the facility on 7/30/24.

During an interview on 9/18/24 at 10:56 a.m., the Director of Health and Wellness indicated the resident did not have a "Medication Self-Administration

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Safety Screen" completed prior to medication self-administration that began on 7/30/24. The safety screen was not completed until 8/5/24.

During an interview on 9/18/24 at 10:56 a.m., the Administrator indicated she hoped the facility followed Indiana state guidelines regarding obtaining the "Medication Self-Administration Safety Screening."

A current facility policy, revised 7/12/23, titled "Medication Self-Administration," provided by the Director of Health and Wellness on 9/18/24 at 10:56 a.m., indicated the following: "Policy: All residents have the right to self-administer medications upon the order of their provider within certain parameters: ... 2. They can demonstrate to the Director Health & Wellness [DHW] or designee that they are capable of stating what condition the medication is treating, following the directions for the medications, and have been assessed using the recognized self-administration of medication assessment in the electronic health record. 3. ...The DHW along with the provider, will made the final determination of the resident's ability to self-administer medications...."

Based on interview and record

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review, the facility failed to ensure a medication self-administration assessment was completed prior to a resident self-administering medications for 1 of 3 residents reviewed for medication self-administration. (Resident C)

Finding includes:

Resident C's clinical record was reviewed on 9/16/24 at 2:04 p.m. The resident admitted to the facility on 7/30/24.

Diagnoses included essential hypertension, unspecified depression, and anxiety.

A provider's order indicated the resident may administer, store, and coordinate all medications without staff assistance.

Current physician orders, dated 7/5/24, included the following: amlodipine (blood pressure) 10 milligrams (mg) - give 1 tablet by mouth daily, losartan (blood pressure) 100 mg - give 1 tablet by mouth daily, bisoprolol (blood pressure) 10 mg - give 1 tablet by mouth daily, and Effexor XR (depression) 150 mg - give 1 capsule by mouth daily.

The clinical record lacked an assessment for self-administration of medications prior to the resident self-administering her medications.

During an interview on 9/18/24

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at 10:17 a.m., Resident C indicated she had been on the same medications prior to admission to the facility. She had been self-administering her own medications since she arrived at the facility on 7/30/24. The facility never administered her medications.

During an interview on 9/18/24 at 10:50 p.m., the Administrator indicated the resident admitted to the facility on 7/30/24.

During an interview on 9/18/24 at 10:56 a.m., the Director of Health and Wellness indicated the resident did not have a "Medication Self-Administration Safety Screen" completed prior to medication self-administration that began on 7/30/24. The safety screen was not completed until 8/5/24.

During an interview on 9/18/24 at 10:56 a.m., the Administrator indicated she hoped the facility followed Indiana state guidelines regarding obtaining the "Medication Self-Administration Safety Screening."

A current facility policy, revised 7/12/23, titled "Medication Self-Administration," provided by the Director of Health and Wellness on 9/18/24 at 10:56 a.m., indicated the following: "Policy: All residents have the right to self-administer

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	medications upon the order of their provider within certain parameters: ... 2. They can demonstrate to the Director Health & Wellness [DHW] or designee that they are capable of stating what condition the medication is treating, following the directions for the medications, and have been assessed using the recognized self-administration of medication assessment in the electronic health record. 3. ...The DHW along with the provider, will made the final determination of the resident's ability to self-administer medications...."			
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 shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to ensure narcotics were reconciled per facility policy for 3 of 3 medication carts reviewed for medication administration and storage. (Assisted Living 2, Assisted Living 1, and Memory Care carts) Findings include:	R 0296	1. The community's med carts were audited by the Director of Health and wellness and designee on 09.22.2024 and 9.26.2024 to ensure the Narc Count and Narc count book were accurate. 2. The community's Director of Health and Wellness, or their designee, shall complete Narc count Audits weekly for 4 weeks, Bi-weekly for 4 weeks and Monthly for 4 Weeks. 3. Current med techs as well as nurses will be re-educated by the Director of Health and Wellness on our policy of	10/10/2024

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1. During a medication administration observation of the Memory Care cart, accompanied by QMA 4 on 9/17/24 at 12:15 p.m., the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:

August 2024-

8/1/24: 11:00 p.m.- 7:00 a.m.

8/2/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/3/24: 3:00 p.m.- 11:00 p.m.

8/4/24: 7:00 p.m.- 11:00 p.m.

8/5/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/6/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/7/24: 7:00 p.m.- 11:00 p.m.

8/8/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/9/24: 7:00 p.m.- 11:00 p.m.

8/10/24: 7:00 p.m.- 11:00 p.m.

8/11/24: 7:00 p.m.- 11:00 p.m.

8/12/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/13/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

Narcotics, Controlled
Substances and preventing
Drug Diversion by 10.10.2024

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8/14/24: 7:00 p.m.- 11:00 p.m.

8/15/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/16/24: 7:00 p.m.- 11:00 p.m.

8/17/24: 7:00 p.m.- 11:00 p.m.

8/18/24: 7:00 p.m.- 11:00 p.m.

8/19/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.8/20/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.8/21/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.8/22/24: 7:00 a.m.- 3:00 p.m.,
3:00 p.m.- 11:00 p.m., and
11:00 p.m.- 7:00 a.m.

8/24/24: 7:00 p.m.- 11:00 p.m.

8/25/24: 7:00 p.m.- 11:00 p.m.

8/26/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.8/27/24: 4:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.8/29/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.8/30/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/31/24: 7:00 p.m.- 11:00 p.m.

September 2024-

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9/1/24: 7:00 p.m.- 11:00 p.m.
9/2/24: 11:00 p.m.- 7:00 a.m.
9/3/24: 2:00 p.m.- 11:00 p.m.
9/4/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.
9/5/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.
9/6/24: 7:00 p.m.- 11:00 p.m.
9/8/24: 11:00 p.m.- 7:00 a.m.
9/9/24: 3:00 p.m.- 11:00 p.m.
9/10/24: 7:00 a.m.- 3:00 p.m.
and 3:00 p.m.- 11:00 p.m.
9/11/24: 12:00 p.m.- 3:00 p.m.
and 3:00 p.m.- 11:00 p.m.
9/12/24: 7:00 p.m.- 11:00 p.m.
9/14/24: 11:00 p.m.- 7:00 a.m.
9/15/24: 3:00 p.m.- 11:00 p.m.
9/16/24: 7:00 p.m.- 11:00 p.m.

During an interview at the time of the observation, QMA 4 indicated the sign in/sign out sheet for narcotics should be completed after two staff members finish counting the narcotic medications and was done at the start and end of every shift.

2. During a medication storage observation, of the Assisted Living 2 cart, on 9/17/24 at

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12:40 p.m., accompanied by QMA 3 the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:

August 2024:

8/1/24: 11:10 p.m.- 7:00 a.m.

8/3/24: 3:00 p.m.- 11:00 p.m.

8/4/24: 3:00 p.m.- 11:00 p.m.

8/5/24: 11:00 p.m.- 7:00 a.m.

8/6/24: 11:15 p.m.- 7:00 a.m.

8/7/24: 3:00 p.m.- 11:00 p.m.

8/8/24: 11:15 p.m.- 7:00 a.m.

8/10/24: 3:00 p.m.- 11:00 p.m.

8/12/24: 11:00 p.m.- 7:00 a.m.

8/13/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/15/24: 11:15 p.m.- 7:00 a.m.

8/17/24: 3:00 p.m.- 11:00 p.m.

8/18/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/19/24: 11:30 p.m.- 7:00 a.m.

8/20/24: 11:15 p.m.- 7:00 a.m.

8/21/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

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8/22/24: 11:20 p.m.- 7:00 a.m.

8/25/24: 7:00 a.m. - 3:00 p.m.
and 11:15 a.m. - 7:00 a.m.

8/26/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/27/24: 11:45 p.m.- 7:00 a.m.

8/29/24: 11:30 p.m.- 7:00 a.m.

8/31/24: 3:00 p.m.- 11:00 p.m.

September 2024-

9/1/24: 3:00 p.m.- 11:00 p.m.

9/2/24: 11:15 p.m.- 7:00 a.m.

9/4/24: 10:30 p.m. - 7:00 a.m.

9/5/24: 11:00 p.m. - 7:00 a.m.

9/6/24: 3:00 p.m. - 11:00 p.m.

9/8/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

9/9/24: 3:00 p.m. - 11:00 p.m.

9/10/24: 7:00 a.m. - 3:00 p.m.

9/11/24: 7:00 a.m. - 3:00 p.m.

9/12/24: 11:00 p.m. - 7:00 a.m.

9/14/24: 3:00 p.m. - 11:00 p.m.
and 11:00 p.m. - 7:00 a.m.

9/15/24: 3:00 p.m. - 11:00 p.m.

9/16/24: 11:00 p.m. - 7:00 a.m.

During an interview, at the time

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of the observation, QMA 3 indicated the sign in/sign out sheet was to be completed at every shift change.

3. During a medication storage observation of the Assisted Living 1 cart, on 9/17/24 at 12:41 p.m. and accompanied by LPN 5, the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:

August 2024-

8/1/24: 7:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m.

8/2/24: 7:00 p.m. - 11:00 p.m.

8/4/24: 11:00 p.m. - 7:00 a.m.

8/5/24: 3:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m.

8/8/24: 11:00 p.m. - 7:00 a.m.

8/10/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.

8/11/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.

8/12/24: 3:00 p.m. - 11:00 p.m. and 3:00 p.m. - 11:00 p.m.

8/13/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m.

8/14/24: 8:00 p.m. - 11:00 p.m.

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8/15/24: 11:00 p.m. - 7:00 a.m.			
8/16/24: 7:00 p.m. - 11:00 p.m.			
8/18/24: 3:00 p.m. - 11:00 p.m.			
8/19/24: 7:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m.			
8/20/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m.			
8/21/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m.			
8/22/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m.			
8/23/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.			
8/24/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.			
8/25/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.			
8/26/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.			
8/27/24: 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m.			
8/28/24: 7:00 a.m. - 3:00 p.m. and 3:00 p.m. - 11:00 p.m.			
8/29/24: 11:00 p.m. - 7:00 a.m.			
8/30/24: 7:00 a.m. - 3:00 p.m.			

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8/31/24: 3:00 p.m. - 11:00 p.m.

September 2024-

9/1/24: 3:00 p.m. - 11:00 p.m.

9/2/24: 7:00 p.m. - 11:00 p.m.
and 11:00 p.m. - 7:00 a.m.

9/3/24: 3:00 p.m. - 11:00 p.m.

9/4/24: 11:00 p.m. - 7:00 a.m.

9/5/24: 11:00 p.m. - 7:00 a.m.

9/8/24: 3:00 p.m. - 7:00 p.m.

9/10/24: 3:00 p.m. - 11:00 p.m.

9/11/24: 3:00 p.m. - 11:00 p.m.

9/12/24: 3:00 p.m. - 11:00 p.m.

9/13/24: 7:00 a.m. - 3:00 p.m.
and 8:00 p.m. - 11:00 p.m.

9/14/24: 3:00 p.m. - 11:00 p.m.

9/15/24: 3:00 p.m. - 11:00 p.m.

9/16/24: 7:00 p.m. - 11:00 p.m.

During an interview at the time of the observation, LPN 5 indicated the sign in/sign out sheet was completed at every shift change by the two staff members exchanging the medication cart keys.

During an interview, on 9/17/24 at 12:44 p.m., the Director of Health and Wellness indicated the expectation was for staff to complete the "Narcotic Count

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Sheet" with exchange of keys and with any change in responsibility of the medication cart.

A current facility policy, revised 7/11/22, titled, "Narcotics, Controlled Substances, and Preventing Drug Diversion", provided by the Director of Health and Wellness, on 9/17/24 at 2:00 p.m., indicated the following: "... c. At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications starting his/her shift, count all narcotic medications and confirm that the amount on hand matches what it listed on the Narcotic Count Sheet for each medication. Both staff members will sign a Narcotic Reconciliation Sheet confirm the accurate count of narcotics on hand...."

Based on record review and interview, the facility failed to ensure narcotics were reconciled per facility policy for 3 of 3 medication carts reviewed for medication administration and storage. (Assisted Living 2, Assisted Living 1, and Memory Care carts)

Findings include:

1. During a medication administration observation of

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the Memory Care cart, accompanied by QMA 4 on 9/17/24 at 12:15 p.m., the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:

August 2024-

8/1/24: 11:00 p.m.- 7:00 a.m.

8/2/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/3/24: 3:00 p.m.- 11:00 p.m.

8/4/24: 7:00 p.m.- 11:00 p.m.

8/5/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/6/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/7/24: 7:00 p.m.- 11:00 p.m.

8/8/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/9/24: 7:00 p.m.- 11:00 p.m.

8/10/24: 7:00 p.m.- 11:00 p.m.

8/11/24: 7:00 p.m.- 11:00 p.m.

8/12/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/13/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/14/24: 7:00 p.m.- 11:00 p.m.

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8/15/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/16/24: 7:00 p.m.- 11:00 p.m.

8/17/24: 7:00 p.m.- 11:00 p.m.

8/18/24: 7:00 p.m.- 11:00 p.m.

8/19/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/20/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/21/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/22/24: 7:00 a.m.- 3:00 p.m.,
3:00 p.m.- 11:00 p.m., and
11:00 p.m.- 7:00 a.m.

8/24/24: 7:00 p.m.- 11:00 p.m.

8/25/24: 7:00 p.m.- 11:00 p.m.

8/26/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/27/24: 4:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/29/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/30/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/31/24: 7:00 p.m.- 11:00 p.m.

September 2024-

9/1/24: 7:00 p.m.- 11:00 p.m.

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9/2/24: 11:00 p.m.- 7:00 a.m.
9/3/24: 2:00 p.m.- 11:00 p.m.
9/4/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.
9/5/24: 7:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.
9/6/24: 7:00 p.m.- 11:00 p.m.
9/8/24: 11:00 p.m.- 7:00 a.m.
9/9/24: 3:00 p.m.- 11:00 p.m.
9/10/24: 7:00 a.m.- 3:00 p.m.
and 3:00 p.m.- 11:00 p.m.
9/11/24: 12:00 p.m.- 3:00 p.m.
and 3:00 p.m.- 11:00 p.m.
9/12/24: 7:00 p.m.- 11:00 p.m.
9/14/24: 11:00 p.m.- 7:00 a.m.
9/15/24: 3:00 p.m.- 11:00 p.m.
9/16/24: 7:00 p.m.- 11:00 p.m.

During an interview at the time of the observation, QMA 4 indicated the sign in/sign out sheet for narcotics should be completed after two staff members finish counting the narcotic medications and was done at the start and end of every shift.

2. During a medication storage observation, of the Assisted Living 2 cart, on 9/17/24 at 12:40 p.m., accompanied by QMA 3 the "Narcotics Sheet

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Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:

August 2024:

8/1/24: 11:10 p.m.- 7:00 a.m.

8/3/24: 3:00 p.m.- 11:00 p.m.

8/4/24: 3:00 p.m.- 11:00 p.m.

8/5/24: 11:00 p.m.- 7:00 a.m.

8/6/24: 11:15 p.m.- 7:00 a.m.

8/7/24: 3:00 p.m.- 11:00 p.m.

8/8/24: 11:15 p.m.- 7:00 a.m.

8/10/24: 3:00 p.m.- 11:00 p.m.

8/12/24: 11:00 p.m.- 7:00 a.m.

8/13/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/15/24: 11:15 p.m.- 7:00 a.m.

8/17/24: 3:00 p.m.- 11:00 p.m.

8/18/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/19/24: 11:30 p.m.- 7:00 a.m.

8/20/24: 11:15 p.m.- 7:00 a.m.

8/21/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/22/24: 11:20 p.m.- 7:00 a.m.

8/25/24: 7:00 a.m. - 3:00 p.m.

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and 11:15 a.m. - 7:00 a.m.

8/26/24: 3:00 p.m.- 11:00 p.m.
and 11:00 p.m.- 7:00 a.m.

8/27/24: 11:45 p.m.- 7:00 a.m.

8/29/24: 11:30 p.m.- 7:00 a.m.

8/31/24: 3:00 p.m.- 11:00 p.m.

September 2024-

9/1/24: 3:00 p.m.- 11:00 p.m.

9/2/24: 11:15 p.m.- 7:00 a.m.

9/4/24: 10:30 p.m. - 7:00 a.m.

9/5/24: 11:00 p.m. - 7:00 a.m.

9/6/24: 3:00 p.m. - 11:00 p.m.

9/8/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

9/9/24: 3:00 p.m. - 11:00 p.m.

9/10/24: 7:00 a.m. - 3:00 p.m.

9/11/24: 7:00 a.m. - 3:00 p.m.

9/12/24: 11:00 p.m. - 7:00 a.m.

9/14/24: 3:00 p.m. - 11:00 p.m.
and 11:00 p.m. - 7:00 a.m.

9/15/24: 3:00 p.m. - 11:00 p.m.

9/16/24: 11:00 p.m. - 7:00 a.m.

During an interview, at the time
of the observation, QMA 3
indicated the sign in/sign out
sheet was to be completed at

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every shift change.

3. During a medication storage observation of the Assisted Living 1 cart, on 9/17/24 at 12:41 p.m. and accompanied by LPN 5, the "Narcotics Sheet Count" was reviewed, and the following dates lacked shift to shift reconciliation of controlled medications:

August 2024-

8/1/24: 7:00 p.m. - 11:00 p.m.
and 11:00 p.m. - 7:00 a.m.

8/2/24: 7:00 p.m. - 11:00 p.m.

8/4/24: 11:00 p.m. - 7:00 a.m.

8/5/24: 3:00 p.m. - 11:00 p.m.
and 11:00 p.m. - 7:00 a.m.

8/8/24: 11:00 p.m. - 7:00 a.m.

8/10/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/11/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/12/24: 3:00 p.m. - 11:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/13/24: 7:00 a.m. - 3:00 p.m.,
3:00 p.m. - 11:00 p.m., and
11:00 p.m. - 7:00 a.m.

8/14/24: 8:00 p.m. - 11:00 p.m.

8/15/24: 11:00 p.m. - 7:00 a.m.

8/16/24: 7:00 p.m. - 11:00 p.m.

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8/18/24: 3:00 p.m. - 11:00 p.m.

8/19/24: 7:00 p.m. - 11:00 p.m.
and 11:00 p.m. - 7:00 a.m.

8/20/24: 7:00 a.m. - 3:00 p.m.,
3:00 p.m. - 11:00 p.m., and
11:00 p.m. - 7:00 a.m.

8/21/24: 7:00 a.m. - 3:00 p.m.,
3:00 p.m. - 11:00 p.m., and
11:00 p.m. - 7:00 a.m.

8/22/24: 7:00 a.m. - 3:00 p.m.,
3:00 p.m. - 11:00 p.m., and
11:00 p.m. - 7:00 a.m.

8/23/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/24/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/25/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/26/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/27/24: 7:00 a.m. - 3:00 p.m.,
3:00 p.m. - 11:00 p.m., and
11:00 p.m. - 7:00 a.m.

8/28/24: 7:00 a.m. - 3:00 p.m.
and 3:00 p.m. - 11:00 p.m.

8/29/24: 11:00 p.m. - 7:00 a.m.

8/30/24: 7:00 a.m. - 3:00 p.m.

8/31/24: 3:00 p.m. - 11:00 p.m.

September 2024-

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9/1/24: 3:00 p.m. - 11:00 p.m.			
9/2/24: 7:00 p.m. - 11:00 p.m. and 11:00 p.m. - 7:00 a.m.			
9/3/24: 3:00 p.m. - 11:00 p.m.			
9/4/24: 11:00 p.m. - 7:00 a.m.			
9/5/24: 11:00 p.m. - 7:00 a.m.			
9/8/24: 3:00 p.m. - 7:00 p.m.			
9/10/24: 3:00 p.m. - 11:00 p.m.			
9/11/24: 3:00 p.m. - 11:00 p.m.			
9/12/24: 3:00 p.m. - 11:00 p.m.			
9/13/24: 7:00 a.m. - 3:00 p.m. and 8:00 p.m. - 11:00 p.m.			
9/14/24: 3:00 p.m. - 11:00 p.m.			
9/15/24: 3:00 p.m. - 11:00 p.m.			
9/16/24: 7:00 p.m. - 11:00 p.m.			
During an interview at the time of the observation, LPN 5 indicated the sign in/sign out sheet was completed at every shift change by the two staff members exchanging the medication cart keys.			

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	During an interview, on 9/17/24 at 12:44 p.m.. the Director of Health and Wellness indicated the expectation was for staff to complete the "Narcotic Count Sheet" with exchange of keys and with any change in responsibility of the medication cart. A current facility policy, revised 7/11/22, titled, "Narcotics, Controlled Substances, and Preventing Drug Diversion", provided by the Director of Health and Wellness, on 9/17/24 at 2:00 p.m., indicated the following: "... c. At the end of each shift, the staff member responsible for medication completing his/her shift, and the staff member responsible for medications starting his/her shift, count all narcotic medications and confirm that the amount on hand matches what it listed on the Narcotic Count Sheet for each medication. Both staff members will sign a Narcotic Reconciliation Sheet confirm the accurate count of narcotics on hand...."			
R 0299	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(3) (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with	R 0299	1.Recommendations from August 2024, Pharmacy audit have been presented and/or emailed to providers for signature and consideration.	10/10/2024

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the facility ' s policy.

Based on record review and interview, the facility failed to act upon pharmacy recommendations for 2 of 4 residents reviewed for pharmacy reviews. (Residents 93 and B)

Findings include:

1. Resident 93's clinical record was reviewed on 9/17/24 at 3:20 p.m. Diagnoses included Parkinson's Disease, urinary spasms, and vitamin D deficiency.

A current physician order, dated 11/9/22, included Ditropan XL extended release 24 hour (overactive bladder) 10 milligrams (mg)- give 1 tablet by mouth two times a day.

A current physician order, dated 7/5/23, included vitamin D (vitamin D deficiency) 125 micrograms/5000 units - give 1 capsule by mouth once daily.

Review of a "Pharmacist's Recommendation to Prescriber," dated 6/13/24, indicated the resident had an order for vitamin D 5000 units daily since September 2022. A recent level was not located. The recommended daily dose was 2000 units once a normal level was reached. Obtain a level and decrease dose if

2. Responses to provider recommendations received will be reviewed by the community's Health and Wellness Director and/or designee. Resident orders will be updated with provider recommendations as appropriate.

3. Pharmacy's recommendations will receive follow up from the Health and Wellness Director and/or designee within 7 business days of receipt of audit. The community's Health and Wellness Director/designee will continue to follow up with provider every 7 days or until confirmation of providers consideration has been received.

4. During monthly Quality Assurance Meetings, the Health and Wellness Director and/or designee will bring results of any non-compliance times 3 months, if 100% compliancy is achieved over this time audits will be discontinued.

5. The Director of Health and Wellness and/or

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appropriate.

Review of a "Pharmacist's Recommendation to Prescriber," dated 8/8/24, indicated the resident had an order for Ditropan XL 24 hour 10 mg twice daily for overactive bladder. This medication was not recommended for use in patients greater than 65 years of age due to risk of increased sedation and anticholinergic effects. Recommend changing to Gemtesa 75 mg daily or Myrbetriq 25 mg daily. These medications did not have anticholinergic properties, making them ideal overactive bladder options for the elderly. If you wish to continue the resident on the current therapy, please consider every day dosing (since it is extended release).

The resident's clinical record lacked indication of prescriber notification, prescriber responses to the above mentioned pharmacy recommendations, medication changes, or lab orders/values.

2. Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnosis included congestive heart failure, atrial fibrillation, and polyneuropathy.

A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive

designee will be re-educated on the policy for Pharmacy Review by the Executive Director by 10.4.2024.

6. The Director of Health and Wellness and or designee will re-educate the team of wellness nurses on the policy for pharmacy review by 10.10.2024.

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impairment.

A pharmacy recommendation, dated 8/8/24, indicated Resident B had an order for Folic Acid (a supplement) three times daily since April. This was a high dose and may not be needed for maintenance. Consider obtaining a folic acid level and decreasing dose if appropriate. The recommendation follow up and provider signature (indicating agreement with recommended actions) date was 9/18/24.

The clinical record lacked a folic acid level result.

A pharmacy recommendation, dated 8/13/24, indicated Resident B had an order for pantoprazole (to treat heartburn) 40 milligrams (mg) twice daily. The only approved indication for twice daily was for short term treatment. Please consider reducing to once daily. If the order was continued at the current dose, please provide risk versus benefit evaluation to support use. The recommendation follow up and provider signature date was 9/18/24.

The clinical record lacked a risk versus benefit evaluation to support the pantoprazole dose continuation.

During an interview on 9/17/24 at 4:41 p.m., the Director of

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Health and Wellness indicated she received the "Pharmacist's Recommendations to the Provider" in her email every 60 days and forwarded them to the provider. A request was made for any provider responses or contraindication letters regarding Resident 93 and Resident B's pharmacy recommendations.

During an interview on 9/17/24 at 5:30 p.m., the Director of Health and Wellness indicated she had not yet received provider responses back from a provider regarding the pharmacy recommendations.

During an interview, on 9/18/24 at 11:30 a.m., the Administrator indicated there was not a policy related to provider reviews or community responses for pharmacy recommendations.

Based on record review and interview, the facility failed to act upon pharmacy recommendations for 2 of 4 residents reviewed for pharmacy reviews. (Residents 93 and B)

Findings include:

1. Resident 93's clinical record was reviewed on 9/17/24 at 3:20 p.m. Diagnoses included Parkinson's Disease, urinary spasms, and vitamin D deficiency.

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A current physician order, dated 11/9/22, included Ditropan XL extended release 24 hour (overactive bladder) 10 milligrams (mg)- give 1 tablet by mouth two times a day.

A current physician order, dated 7/5/23, included vitamin D (vitamin D deficiency) 125 micrograms/5000 units - give 1 capsule by mouth once daily.

Review of a "Pharmacist's Recommendation to Prescriber," dated 6/13/24, indicated the resident had an order for vitamin D 5000 units daily since September 2022. A recent level was not located. The recommended daily dose was 2000 units once a normal level was reached. Obtain a level and decrease dose if appropriate.

Review of a "Pharmacist's Recommendation to Prescriber," dated 8/8/24, indicated the resident had an order for Ditropan XL 24 hour 10 mg twice daily for overactive bladder. This medication was not recommended for use in patients greater than 65 years of age due to risk of increased sedation and anticholinergic effects. Recommend changing to Gemtesa 75 mg daily or Myrbetriq 25 mg daily. These medications did not have anticholinergic properties, making them ideal overactive

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bladder options for the elderly. If you wish to continue the resident on the current therapy, please consider every day dosing (since it is extended release).

The resident's clinical record lacked indication of prescriber notification, prescriber responses to the above mentioned pharmacy recommendations, medication changes, or lab orders/values.

2. Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnosis included congestive heart failure, atrial fibrillation, and polyneuropathy.

A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive impairment.

A pharmacy recommendation, dated 8/8/24, indicated Resident B had an order for Folic Acid (a supplement) three times daily since April. This was a high dose and may not be needed for maintenance. Consider obtaining a folic acid level and decreasing dose if appropriate. The recommendation follow up and provider signature (indicating agreement with recommended actions) date was 9/18/24.

The clinical record lacked a folic acid level result.

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A pharmacy recommendation, dated 8/13/24, indicated Resident B had an order for pantoprazole (to treat heartburn) 40 milligrams (mg) twice daily. The only approved indication for twice daily was for short term treatment. Please consider reducing to once daily. If the order was continued at the current dose, please provide risk versus benefit evaluation to support use. The recommendation follow up and provider signature date was 9/18/24.

The clinical record lacked a risk versus benefit evaluation to support the pantoprazole dose continuation.

During an interview on 9/17/24 at 4:41 p.m., the Director of Health and Wellness indicated she received the "Pharmacist's Recommendations to the Provider" in her email every 60 days and forwarded them to the provider. A request was made for any provider responses or contraindication letters regarding Resident 93 and Resident B's pharmacy recommendations.

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During an interview on 9/17/24 at 5:30 p.m., the Director of Health and Wellness indicated she had not yet received provider responses back from a provider regarding the pharmacy recommendations.

During an interview, on 9/18/24 at 11:30 a.m., the Administrator indicated there was not a policy related to provider reviews or community responses for pharmacy recommendations.

Based on record review and interview, the facility failed to act upon pharmacy recommendations for 2 of 4 residents reviewed for pharmacy reviews. (Residents 93 and B)

Findings include:

1. Resident 93's clinical record was reviewed on 9/17/24 at 3:20 p.m. Diagnoses included Parkinson's Disease, urinary spasms, and vitamin D deficiency.

A current physician order, dated 11/9/22, included Ditropan XL extended release 24 hour (overactive bladder) 10 milligrams (mg)- give 1 tablet by mouth two times a day.

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A current physician order, dated 7/5/23, included vitamin D (vitamin D deficiency) 125 micrograms/5000 units - give 1 capsule by mouth once daily.

Review of a "Pharmacist's Recommendation to Prescriber," dated 6/13/24, indicated the resident had an order for vitamin D 5000 units daily since September 2022. A recent level was not located. The recommended daily dose was 2000 units once a normal level was reached. Obtain a level and decrease dose if appropriate.

Review of a "Pharmacist's Recommendation to Prescriber," dated 8/8/24, indicated the resident had an order for Ditropan XL 24 hour 10 mg twice daily for overactive bladder. This medication was not recommended for use in patients greater than 65 years of age due to risk of increased sedation and anticholinergic effects. Recommend changing to Gemtesa 75 mg daily or Myrbetriq 25 mg daily. These medications did not have anticholinergic properties, making them ideal overactive bladder options for the elderly. If you wish to continue the resident on the current therapy, please consider every day dosing (since it is extended release).

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The resident's clinical record lacked indication of prescriber notification, prescriber responses to the above mentioned pharmacy recommendations, medication changes, or lab orders/values.

2. Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnosis included congestive heart failure, atrial fibrillation, and polyneuropathy.

A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive impairment.

A pharmacy recommendation, dated 8/8/24, indicated Resident B had an order for Folic Acid (a supplement) three times daily since April. This was a high dose and may not be needed for maintenance. Consider obtaining a folic acid level and decreasing dose if appropriate. The recommendation follow up and provider signature (indicating agreement with recommended actions) date was 9/18/24.

The clinical record lacked a folic acid level result.

A pharmacy recommendation, dated 8/13/24, indicated Resident B had an order for pantoprazole (to treat heartburn) 40 milligrams (mg) twice daily. The only approved indication for twice daily was for short term

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treatment. Please consider reducing to once daily. If the order was continued at the current dose, please provide risk versus benefit evaluation to support use. The recommendation follow up and provider signature date was 9/18/24.

The clinical record lacked a risk versus benefit evaluation to support the pantoprazole dose continuation.

During an interview on 9/17/24 at 4:41 p.m., the Director of Health and Wellness indicated she received the "Pharmacist's Recommendations to the Provider" in her email every 60 days and forwarded them to the provider. A request was made for any provider responses or contraindication letters regarding Resident 93 and Resident B's pharmacy recommendations.

During an interview on 9/17/24 at 5:30 p.m., the Director of Health and Wellness indicated she had not yet received provider responses back from a provider regarding the pharmacy recommendations.

During an interview, on 9/18/24 at 11:30 a.m., the Administrator indicated there was not a policy related to provider reviews or community responses for pharmacy recommendations.

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Based on record review and interview, the facility failed to act upon pharmacy recommendations for 2 of 4 residents reviewed for pharmacy reviews. (Residents 93 and B)

Findings include:

1. Resident 93's clinical record was reviewed on 9/17/24 at 3:20 p.m. Diagnoses included Parkinson's Disease, urinary spasms, and vitamin D deficiency.

A current physician order, dated 11/9/22, included Ditropan XL extended release 24 hour (overactive bladder) 10 milligrams (mg)- give 1 tablet by mouth two times a day.

A current physician order, dated 7/5/23, included vitamin D (vitamin D deficiency) 125 micrograms/5000 units - give 1 capsule by mouth once daily.

Review of a "Pharmacist's Recommendation to Prescriber," dated 6/13/24, indicated the resident had an order for vitamin D 5000 units daily since September 2022. A recent level was not located. The recommended daily dose was 2000 units once a normal level was reached. Obtain a level and decrease dose if appropriate.

Review of a "Pharmacist's

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Recommendation to Prescriber," dated 8/8/24, indicated the resident had an order for Ditropan XL 24 hour 10 mg twice daily for overactive bladder. This medication was not recommended for use in patients greater than 65 years of age due to risk of increased sedation and anticholinergic effects. Recommend changing to Gemtesa 75 mg daily or Myrbetriq 25 mg daily. These medications did not have anticholinergic properties, making them ideal overactive bladder options for the elderly. If you wish to continue the resident on the current therapy, please consider every day dosing (since it is extended release).

The resident's clinical record lacked indication of prescriber notification, prescriber responses to the above mentioned pharmacy recommendations, medication changes, or lab orders/values.

2. Resident B's clinical record was reviewed on 9/16/24 at 2:34 p.m. Diagnosis included congestive heart failure, atrial fibrillation, and polyneuropathy.

A 7/25/24, "Care Evaluation and Service Plan" indicated Resident B had cognitive impairment.

A pharmacy recommendation,

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dated 8/8/24, indicated Resident B had an order for Folic Acid (a supplement) three times daily since April. This was a high dose and may not be needed for maintenance. Consider obtaining a folic acid level and decreasing dose if appropriate. The recommendation follow up and provider signature (indicating agreement with recommended actions) date was 9/18/24.

The clinical record lacked a folic acid level result.

A pharmacy recommendation, dated 8/13/24, indicated Resident B had an order for pantoprazole (to treat heartburn) 40 milligrams (mg) twice daily. The only approved indication for twice daily was for short term treatment. Please consider reducing to once daily. If the order was continued at the current dose, please provide risk versus benefit evaluation to support use. The recommendation follow up and provider signature date was 9/18/24.

The clinical record lacked a risk versus benefit evaluation to support the pantoprazole dose continuation.

During an interview on 9/17/24 at 4:41 p.m., the Director of Health and Wellness indicated she received the "Pharmacist's

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	Recommendations to the Provider" in her email every 60 days and forwarded them to the provider. A request was made for any provider responses or contraindication letters regarding Resident 93 and Resident B's pharmacy recommendations. During an interview on 9/17/24 at 5:30 p.m., the Director of Health and Wellness indicated she had not yet received provider responses back from a provider regarding the pharmacy recommendations. During an interview, on 9/18/24 at 11:30 a.m., the Administrator indicated there was not a policy related to provider reviews or community responses for pharmacy recommendations.			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to	R 0304	1. Current QMA's and nurses will be re-educated on the Indiana State Regulation on Medication Management and Medication Management policy, which identifies how medications must be stored by the Director of Health and Wellness and/or designee completed by 10.10.2024. 2. The Health and Wellness Director and/or designee will audit	10/10/2024

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ensure medication carts were appropriately locked when authorized personnel were not present for 1 of 3 carts reviewed for medication administration. (Assisted Living 2 cart)

Findings include:

During an observation on 9/17/24 at 12:33 p.m., the Assisted Living (AL) 2 medication cart was found to be unlocked and unattended in front of the nurse station. A member of the housekeeping staff, who was working nearby, indicated they would attempt to locate the staff member responsible for the medication cart.

During an observation and interview on 9/17/24 at 12:40 p.m., QMA 3 arrived at the AL 2 medication cart and indicated she was not aware she had forgotten to lock the medication cart before leaving the area.

During an interview on 9/17/24 at 12:44 p.m., the Director of Health and Wellness indicated the expectation was for staff to lock the medication cart before leaving it unattended.

A current facility policy, revised 7/11/22, titled, "Narcotics, Controlled Substances, and Preventing Drug Diversion", provided by the Director of Health and Wellness, on 9/17/24 at 2:00 p.m., indicated

medication carts on a weekly basis for the next 4 weeks and then biweekly for 4 weeks to ensure compliance of locked med carts when the authorized personnel are not present.

3. The Health and Wellness Director and Executive Director will conduct random audits to ensure the Medication Carts/storage are secured when unattended.

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the following: "... All medications, including over-the-counter medications, are always kept in locked storage...."

Based on observation and interview, the facility failed to ensure medication carts were appropriately locked when authorized personnel were not present for 1 of 3 carts reviewed for medication administration. (Assisted Living 2 cart)

Findings include:

During an observation on 9/17/24 at 12:33 p.m., the Assisted Living (AL) 2 medication cart was found to be unlocked and unattended in front of the nurse station. A member of the housekeeping staff, who was working nearby, indicated they would attempt to locate the staff member responsible for the medication cart.

During an observation and interview on 9/17/24 at 12:40 p.m., QMA 3 arrived at the AL 2 medication cart and indicated she was not aware she had forgotten to lock the medication cart before leaving the area.

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	During an interview on 9/17/24 at 12:44 p.m., the Director of Health and Wellness indicated the expectation was for staff to lock the medication cart before leaving it unattended. A current facility policy, revised 7/11/22, titled, "Narcotics, Controlled Substances, and Preventing Drug Diversion", provided by the Director of Health and Wellness, on 9/17/24 at 2:00 p.m., indicated the following: "... All medications, including over-the-counter medications, are always kept in locked storage...."			
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record.	R 0356	1. The Director of Health and Wellness and/or designee have completed chart audits on current residents for code status verses resident current orders. Resident orders found to be non-compliant have been corrected by 10.3.2024. 2. Residents that are found to be non-compliant with not having a completed Indiana Post form will be corrected by 11.15.2024. 3. New resident move in's will be audited to ensure all emergency	11/15/2024

(5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death.

(6) Information on any known allergies.

(7) A photograph (for identification of the resident).

(8) Copy of advance directives, if available.

Based on record review and interview, the facility failed to ensure a resident's desired code status was accurately reflected in the clinical record for 1 of 7 residents reviewed for emergency information.
(Resident D)

Finding includes:

Resident D's clinical record was reviewed on 9/16/24 at 3:57 p.m. The resident's admission date was 1/5/24. Diagnoses included atherosclerotic heart disease, chronic kidney disease, and essential primary hypertension.

The banner bar, found in the electronic health record below the resident's identification upon opening the resident's electronic record, included the following code status: cardiopulmonary resuscitation (CPR)- attempt resuscitation.

information
is on record.

A current physician order, dated 1/5/24, included CPR - attempt resuscitation.

A code status sticker, below the resident's room number on the outside of the paper chart binder stored at the Nurse's Station indicated CPR.

The current advanced directive, dated 6/17/24, in the resident's paper chart binder indicated the following was selected: "Do Not Attempt Resuscitation" (DNR). The advanced directive was signed by the resident and the physician.

The signed service plan, dated 8/29/24, indicated the resident was oriented and independent with decisions about their care and environment. The resident made safe judgments and was able to recall and retain information (8/5/24). The service plan lacked information regarding the resident's code status wishes.

During an interview on 9/17/24 at 2:59 p.m., LPN 5 indicated the resident's paper and electronic clinical record did not reflect the resident's current chosen code status. The electronic record had a "CPR-attempt resuscitation" order and banner bar, which she referred to during emergencies. She indicated this was inconsistent with the resident's

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current DNR advanced directive dated 6/17/24. The person who received the advanced directive should have ensured the entire clinical record reflected the code status changes when it was placed in the chart.

During an interview on 9/17/24 at 4:38 p.m., the Health and Wellness Director indicated the resident's current code status was not updated and consistent throughout the paper and electronic clinical record. The resident's current advanced directive, dated 6/17/24, included a DNR code status while the paper and electronic record directed staff to attempt resuscitation. All areas of the resident's clinical record should have reflected the resident's choice on the advanced directive.

A current facility policy, revised 6/20/22, titled "Advance Directives," provided by the Director of Health and Wellness on 9/16/24 at 9:45 a.m., indicated the following: "Policy Statement... Advance directives will be respected in accordance with state law and community policy... Policy Interpretation and Implementation... 18. Changes or revocations of an advance directive must be submitted in writing to the DHW [Director of Health and Wellness]... 19. The DHW or designee will notify the

attending provider of advance directives so that appropriate orders can be documented in the resident's medical record and service plan...."

Based on record review and interview, the facility failed to ensure a resident's desired code status was accurately reflected in the clinical record for 1 of 7 residents reviewed for emergency information.
(Resident D)

Finding includes:

Resident D's clinical record was reviewed on 9/16/24 at 3:57 p.m. The resident's admission date was 1/5/24. Diagnoses included atherosclerotic heart disease, chronic kidney disease, and essential primary hypertension.

The banner bar, found in the electronic health record below the resident's identification upon opening the resident's electronic record, included the following code status: cardiopulmonary resuscitation (CPR)- attempt resuscitation.

A current physician order, dated 1/5/24, included CPR - attempt resuscitation.

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The current advanced directive, dated 6/17/24, in the resident's paper chart binder indicated the following was selected: "Do Not Attempt Resuscitation" (DNR). The advanced directive was signed by the resident and the physician.

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clinical record reflected the code status changes when it was placed in the chart.

During an interview on 9/17/24 at 4:38 p.m., the Health and Wellness Director indicated the resident's current code status was not updated and consistent throughout the paper and electronic clinical record. The resident's current advanced directive, dated 6/17/24, included a DNR code status while the paper and electronic record directed staff to attempt resuscitation. All areas of the resident's clinical record should have reflected the resident's choice on the advanced directive.

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FORM APPROVED

OMB NO. 0938-0391

	and service plan...."			
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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
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