

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 05/15/2022
NAME OF PROVIDER OR SUPPLIER FORT HARRISON ALF OPERATIONS		STREET ADDRESS, CITY, STATE, ZIP CODE 8025 DOUBLEDAY DRIVE, INDIANAPOLIS, , 46216			
(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 IN00379471. Complaint IN00379471 - Substantiated. State Residential Findings related to the allegations are cited at R0091. Survey date: May 14 and 15, 2022 Facility number: 014109 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 17, 2022	R 0000	05/27/2022 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Complaint Survey Wickshire Fort Harrison 8025 Doubleday drive Indianapolis, IN46216 Dear Ms. Buroker, On May 15, 2022, a Complaint (IN00379471) was conducted at the above referenced facility by the Division of Long-Term Care. Please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and		

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			Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of June 13th ,2022 Please feel free to call me with any further questions at 1 (317)-546-2846. Respectfully submitted, Romeo Behl (Executive Director) Wickshire Fort Harrison 8025 Doubleday drive Indianapolis, IN 46216	
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration.	R 0091	R091 Administration and management The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	06/13/2022

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(4) Facility operations.

The policies shall be made available to residents upon request.

Based on observation, interview, and record review, the facility failed to implement the Controlled Substances Policy by not timely and fully completing the community inventory count form with the potential to affect 40 of 40 residents residing at the facility.

Findings include:

On 5/14/22 at 11:50 p.m., the facility narcotic control binder was observed. The binder contained a Controlled Substance Community Inventory Count Form, which instructed the nursing staff sign their name on the form at each shift change for the oncoming and off going nursing staff.

The form contained the signature of only one staff person, or no signatures, on the following date(s)/time(s):

5/3/22 at 6:00 a.m.,

5/3/22 at 10:00 p.m.,

5/4/22 at 6:00 a.m.,

5/4/22 at 2:00 p.m.,

5/4/22 at 10:00 p.m.,

deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.1) Immediate actions taken for those residents identified:

Count verified witnessed by 2 staff members and no issues with medication count noted. Education provided to clinical staff by RDCO on 4/28/2022 for signing control substance count sheet during shift changes.

2) How the facility identified other residents:

Any resident residing in the facility had the potential to be affected. No other residents residing in the facility were affected by this deficiency.

3) Measures put into place/ System changes.

Control substance count sheet will be signed by On-coming and Off-going authorized staff member. HWD/designee will audit control substance sheet starting 4/28/22 and then weekly x4 weeks then monthly x 4 months

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5/5/22 at 6:00 a.m.,

5/6/22 at 6:00 a.m.,

5/6/22 at 10:00 p.m.,

5/7/22 at 2:00 p.m.,

5/7/22 at 10:00 p.m.,

5/8/22 for all 3 shifts,

5/9/22 for all 3 shifts,

5/10/22 for all 3 shifts,

5/11/22 for all 3 shifts,

5/12/22 at 10:00 p.m.,

5/13/22 at 2:00 p.m.,

5/13/22 at 10:00 p.m., &

5/14/22 for all 3 shifts.

4) How the corrective actions will be monitored:

The HWD/designee will be responsible for compliance. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.
5) Date of compliance:06/13/2022.

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An interview conducted with the Executive Director (ED), on 5/15/22 at 2:15 a.m., indicated the Community Inventory Count Form appeared incomplete. There should be a second staff person to conduct a narcotic count during shift change. Since there was no Nurse or Qualified Medication Aide (QMA) on night shift the Nurse or QMA would place the medication cart keys in a locked box before they left. The narcotic count could be conducted with a Certified Nursing Assistant (CNA) as long as they were not directly handling the narcotic medications.

A policy titled "Controlled Substances", dated 11/1/19, was provided by the ED on 5/15/22 at 2:10 a.m. The policy indicated the following, "...5. Prior to the end of each shift the authorized associated that is reported off duty will count the controlled substances with the authorized associate with is reporting on duty...6. The counts will be recorded on the forms listed above...a. Both associates will initial and sign the form verifying that the count is correct...."

This State tag relates to Complaint IN00379471.

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Controlled Substances Policy by not timely and fully completing the community inventory count form with the potential to affect 40 of 40 residents residing at the facility.

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5/9/22 for all 3 shifts,

5/10/22 for all 3 shifts,

5/11/22 for all 3 shifts,

5/12/22 at 10:00 p.m.,

5/13/22 at 2:00 p.m.,

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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