STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER BIRCH OF KOKOMO	408 S WASHINGTON STREET, KOKOMO, , 46901

(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 Complaints IN00357971 and IN00358213. Complaint IN00357971-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00358213-Substantiated. State deficiencies related to the allegations were cited at R055. Unrelated deficiencies are cited. Survey date: July 23 and 26, 2021 Facility number: 014137 Residential Census: 110 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5. Quality review completed on August 6, 2021.	R 0000	R 0000 Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction for this survey. Please find the sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, please feel free to contact me. Sincerely, Angela M Mann,	

			HFA, RCA, CNA Executive Director	
R 0055	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(y)(1-4) (y) Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: (1) Bathing. (2) Personal care. (3) Physical examinations and treatments. (4) Visitations. Based on interview and record review, the facility failed to ensure a resident was allowed to have visitors in the privacy of her own apartment for 1 of 4 residents reviewed for the right to privacy during visitations (Resident C). Finding includes: A Confidential interview was conducted during the course of the survey. The Confidential interviewee indicated she was not allowed to visit her loved one in her apartment unless she agreed to take a COVID-19 test. She did not think she should have to take a COVID-19 test everyday she visited, when the	R 0055	**Tag;** **Title; Deficiency or Offense:** **R 055 Residents' Rights – Deficiency** **Residents have the right to be treated as individuals with consideration and respect for their privacy. Privacy shall be afforded for at least the following: Bathing, Personal care, Physical examinations and treatments, Visitations.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Executive Director or Designee to provide accommodations for visitation with privacy for residents in accordance with the current	09/17/2021

	vaccinated visitors and the staff was not required to take a COVID-19 test everyday they came into the building. She would not always have to take the COVID-19 test depending on who was sitting at the desk when she came in. Some of the desk staff knew who she was and let her go to her loved one's room without taking the test. If she did not take the COVID-19 test she was only allowed to visit with the resident in the lobby. The lobby was not a private place for her to visit with her loved one, so she stopped visiting as much because she and her loved one were not going to sit down in the lobby and be exposed to the other residents who did not have a mask on when she could go up to her loved one's apartment and safely socially distance and be at a lower risk of acquiring COVID-19. During an interview on 7/26/21 at 11:10 a.m., the ED (Executive Director) indicated unvaccinated visitors were asked to take a rapid COVID-19 nasal swab test to determine if they were infected with COVID-19 or not. If the visitor's test was negative, the person was asked to keep his or her mask on at all times, then the visitor was escorted by a staff member to the resident's room. If the visitor declined to take the rapid nasal swab test, the visit for that day had to		CDC visitation guidelines, which currently includes visitation in a residents' apartment and/or another location within the community and/or grounds. **<u>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;</u>** The residents of the community have the potential to be affected by the alleged Deficiency. The Executive Director or Designee to assure visitors are provided accommodations for privacy during visitation with residents of the community. Visitation will be in accordance with current CDC visitation guidelines, which currently includes visitation in a residents' apartment and/or another location within the community and/or grounds.	

	occur in the front lobby of the facility or outside. The residents were brought to the front lobby by a staff member, or they brought themselves to the lobby. If the visitor tested positive, they were immediately sent home. Vaccinated visitors were allowed to go up to the residents' room whom they were visiting without an escort, and they were not asked to take a COVID-19 test prior to going to the resident's room. During an interview on 7/26/21 at 12:49 p.m., the ED, Receptionist 3, and Receptionist 4 were in attendance. Receptionist 3 indicated she was trained by Receptionist 5 to ask the visitors if they were vaccinated and if they are vaccinated, she was to check the visitor's vaccination card. If they were unvaccinated, then she called the nurse to come down and do a COVID-19 test on the visitor. If the visitor refused to have the COVID-19 test performed she had them sit down in the front lobby and if the resident needed brought down, a staff member brought the resident to the front lobby otherwise, she called and notified the resident a visitor was in the front lobby to visit him or her. They were allowed to visit outside if they wanted. Receptionist 4 indicated she performed the same visitor screen procedure as		**<u>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;</u>** Executive Director or Designee to provide an in-service to staff on or before 09/17/2021 regarding current CDC visitation guidelines. **<u>How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;</u>** The Executive Director to ensure CDC visitation guidelines are posted at receptionist desk for staff to reference when visitors enter the community for visitation.	

	Receptionist 3 performed. During an interview on 7/26/21 at 2:14 p.m., Receptionist 5 indicated she was instructed by the ED to actually check the visitor's vaccination card for the vaccination status. Unvaccinated visitors were asked to take a COVID-19 test prior to visiting in a resident's room, then they would be escorted to the resident's room if their test was negative. Unvaccinated visitors who refused to take the COVID test were not allowed to visit in the resident's room. The visit took place in the front lobby or outside. Vaccinated visitors walked up to the resident's rooms after being screened into the facility. Residents and visitors were complaining about the COVID-19 tests and visitors were refusing to take the test, so the residents were brought down or came down to the front lobby or outside to visit. During a confidential interview during the survey, an unidentified resident indicated if a resident's visitor did not have the vaccine and did not take the COVID-19 test, then the resident and the visitor had to sit outside in the "sweltering hot sun" to visit or in the "noisy" front lobby, so visitors were not able to visit residents. A current policy and procedure		**<u>What date the systemic changes will be completed:</u> 09/17/2021** A CQI tool will be implemented on or before 09/17/2021 to ensure compliance is maintained. The Executive Director or Designee will monitor randomly every month for a period of 6 months. We respectfully request a paper compliance for the alleged Deficiency.	

	titled, "Visitation Guidelines for Long-term Care Facilities," dated July 26, 2021, at 12:00 p.m., sent by email from Vice President for Clinical Services, provided by the ED on 7/26/21 at 1:28 p.m., indicated "Participate in and pass a symptom screening and temperature check. Facilities shall also require visitors to sign in and attest to their current COVID status and symptoms. There should be a visitor log that includes name of visitor, contact information and start and end time of visit....Wear a mask at all times while visiting, Maintain at least 6 feet physical distance from all residents in the facility..." A current policy and procedure titled "Statement of Resident's Rights" dated 11/8/2019, provided by the ED on 7/26/21 at 1:28 p.m., indicated "...Each resident shall have the right to...5. Be treated as an individual with consideration and respect for his or her privacy. Privacy shall be afforded for at least bathing, personal care, physical examination and treatments and visitations...31. Choose with whom he or she associates and have visitors of his or her choice to the extent the health, safety and well-being of others are not disturbed and in accordance with the Lease...."			

	The Division of Long Term Care Newsletter titled, "Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination," last updated July 1, 2021, indicated facilities were not allowed to restrict visitation without a reasonable clinical or safety cause. Full vaccination for visitors was preferred, when possible; however, visitation may not be denied based on vaccination status. Indoor visitation was to be allowed at all times and was not to be limited. The facilities needed to provide visitation with an adequate degree of privacy. Visitation in the residents' rooms offered a greater degree of privacy. During indoor visits visitors should go directly to the resident's room or designated visitation area. While visits in designated visitation areas was still encouraged, in-room visits were allowed while adhering to the core principles of COVID-19 infection prevention. If the resident and all of resident's visitors were fully vaccinated, residents and their visitors may choose to have close contact including touch and to not wear facemasks if simultaneous visits were not occurring in the same area while alone in the resident's room or the designed visitation room. However, the visitors should wear a mask, and physically distance if interacting with staff and other residents in the facility. If the			

	resident or visitor was not fully vaccinated, ideally both should wear a facemask and physically distance. If the resident was fully vaccinated and would like to have close contact (physical touch) with their visitor, that can be allowed after both the resident and the visitor perform hand hygiene and wear well-fitting facemasks. This State finding relates to Complaint IN00358213. Based on interview and record review, the facility failed to ensure a resident was allowed to have visitors in the privacy of her own apartment for 1 of 4 residents reviewed for the right to privacy during visitations (Resident C). Finding includes: A Confidential interview was conducted during the course of the survey. The Confidential interviewee indicated she was not allowed to visit her loved one in her apartment unless she agreed to take a COVID-19 test. She did not think she should have to take a COVID-19 test everyday she visited, when the vaccinated visitors and the staff was not required to take a COVID-19 test everyday they came into the building. She would not always have to take the COVID-19 test depending on who was sitting at the desk			

	when she came in. Some of the desk staff knew who she was and let her go to her loved one's room without taking the test. If she did not take the COVID-19 test she was only allowed to visit with the resident in the lobby. The lobby was not a private place for her to visit with her loved one, so she stopped visiting as much because she and her loved one were not going to sit down in the lobby and be exposed to the other residents who did not have a mask on when she could go up to her loved one's apartment and safely socially distance and be at a lower risk of acquiring COVID-19. During an interview on 7/26/21 at 11:10 a.m., the ED (Executive Director) indicated unvaccinated visitors were asked to take a rapid COVID-19 nasal swab test to determine if they were infected with COVID-19 or not. If the visitor's test was negative, the person was asked to keep his or her mask on at all times, then the visitor was escorted by a staff member to the resident's room. If the visitor declined to take the rapid nasal swab test, the visit for that day had to occur in the front lobby of the facility or outside. The residents were brought to the front lobby by a staff member, or they brought themselves to the lobby. If the visitor tested positive, they were immediately			

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	vaccination status. Unvaccinated visitors were asked to take a COVID-19 test prior to visiting in a resident's room, then they would be escorted to the resident's room if their test was negative. Unvaccinated visitors who refused to take the COVID test were not allowed to visit in the resident's room. The visit took place in the front lobby or outside. Vaccinated visitors walked up to the resident's rooms after being screened into the facility. Residents and visitors were complaining about the COVID-19 tests and visitors were refusing to take the test, so the residents were brought down or came down to the front lobby or outside to visit. During a confidential interview during the survey, an unidentified resident indicated if a resident's visitor did not have the vaccine and did not take the COVID-19 test, then the resident and the visitor had to sit outside in the "sweltering hot sun" to visit or in the "noisy" front lobby, so visitors were not able to visit residents. A current policy and procedure titled, "Visitation Guidelines for Long-term Care Facilities," dated July 26, 2021, at 12:00 p.m., sent by email from Vice President for Clinical Services, provided by the ED on 7/26/21 at 1:28 p.m., indicated			

	"Participate in and pass a symptom screening and temperature check. Facilities shall also require visitors to sign in and attest to their current COVID status and symptoms. There should be a visitor log that includes name of visitor, contact information and start and end time of visit....Wear a mask at all times while visiting, Maintain at least 6 feet physical distance from all residents in the facility..." A current policy and procedure titled "Statement of Resident's Rights" dated 11/8/2019, provided by the ED on 7/26/21 at 1:28 p.m., indicated "...Each resident shall have the right to...5. Be treated as an individual with consideration and respect for his or her privacy. Privacy shall be afforded for at least bathing, personal care, physical examination and treatments and visitations...31. Choose with whom he or she associates and have visitors of his or her choice to the extent the health, safety and well-being of others are not disturbed and in accordance with the Lease...." The Division of Long Term Care Newsletter titled, "Long-term Care Facilities Guidelines in Response to COVID-19 Vaccination," last updated July 1, 2021, indicated facilities were not allowed to restrict visitation			

	without a reasonable clinical or safety cause. Full vaccination for visitors was preferred, when possible; however, visitation may not be denied based on vaccination status. Indoor visitation was to be allowed at all times and was not to be limited. The facilities needed to provide visitation with an adequate degree of privacy. Visitation in the residents' rooms offered a greater degree of privacy. During indoor visits visitors should go directly to the resident's room or designated visitation area. While visits in designated visitation areas was still encouraged, in-room visits were allowed while adhering to the core principles of COVID-19 infection prevention. If the resident and all of resident's visitors were fully vaccinated, residents and their visitors may choose to have close contact including touch and to not wear facemasks if simultaneous visits were not occurring in the same area while alone in the resident's room or the designed visitation room. However, the visitors should wear a mask, and physically distance if interacting with staff and other residents in the facility. If the resident or visitor was not fully vaccinated, ideally both should wear a facemask and physically distance. If the resident was fully vaccinated and would like to have close contact (physical touch) with their visitor, that can			

	be allowed after both the resident and the visitor perform hand hygiene and wear well-fitting facemasks. This State finding relates to Complaint IN00358213.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.	R 0117	**Tag; Title; Deficiency or Offense:** **R 117** **Personnel – Deficiency** **Staff shall be sufficient in number, qualification and training in accordance with applicable state laws and rules to meet the twenty-four hour, scheduled and unscheduled needs of the residents and services provided** **What corrective action will be accomplished for those residents found to have been affected by the deficiency:** The Executive Director or Designee	09/17/2021

	Based on interview and record review, the facility failed to ensure licensed and appropriately trained staff were available to provide ordered medications to 1 of 3 residents reviewed for care on the midnight shift (Resident G). Finding includes: During an interview on 7/26/21 at 2:49 p.m., Resident G indicated he had not been given his 2:00 a.m., dose of pain medication on several occasions due to there was no QMA (Qualified Medication Aide) or nurse scheduled to work on those night shifts when his medication was not given. He had not received his pain medication for the last three mornings because there was no licensed personnel available to give it to him. He asked his Physician if he could take the medication himself if the staff left the pill at his bedside prior to them leaving on the afternoon shift and his Physician indicated he was not going to write the order for him to administer his medication because the facility was supposed to be responsible for administering his medications. During an interview on 7/26/21 at 3:30 p.m., LPN 2 and LPN 7 were in attendance. LPN 7 indicated she did not realize		to ensure licensed and appropriately trained staff is available twenty-four hours, to meet the needs of residents' physician prescribed medication(s) orders. **<u>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;</u>** The residents of the community receiving physician prescribed medication(s) from the nursing staff have the potential to be affected by the alleged Deficiency. The Executive Director or Designee to ensure licensed and appropriately trained staff are available twenty-four hours, via in person and/or on call and listed on daily nursing schedule and available to ensure physician prescribed medication(s) for residents are administered per physician orders.	

	Resident G had a medication ordered to be administered at 2:00 a.m. All the residents who had medications scheduled on the night shift, were given those medications prior to the evening shift leaving, then the residents administered the medications to themselves at the times they were due to be given . Resident G was not a candidate to self-administer his own medications, so he had to have his medication at 2:00 a.m., administered by a nurse or a QMA. Resident G's record was reviewed on 7/26/21 at 4:30 p.m. Diagnoses included, but were not limited to, heart failure, muscle spasms, chronic kidney disease and type 2 Diabetes Mellitus. The resident's June 2021 EMAR (Electronic Medication Administration Record) was reviewed for the administration of his Oxycodone 30 (a potent narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 6/2/2021, 6/3/21, 6/4/21, 6/18/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21. The "Controlled Drug Use		**What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Executive Director or Designee to revise the daily nursing schedule to ensure licensed and appropriately trained staff are scheduled and/or available twenty-four hours a day, seven days a week to administer physician prescribed medication(s) to residents, per physician orders. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;** The Executive Director or Designee to revise the Daily Nursing Schedule form on or before 09/01/2021, to reflect and ensure licensed and appropriately trained staff are scheduled and/or available and/or on call at all	

	Record" dated 5/26/21 through 6/11/21, indicated there was no Oxycodone 30 mg signed out on the narcotic sheet as being administered for the following dates at the scheduled time of 2 a.m. for the month of June 2021: 6/2/21, 6/3/21, 6/4/21, 6/5/21, 6/6/21, 6/12/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21. The resident's July 2021 EMAR (Electronic Medication Administration Record) was reviewed for the administration of his Oxycodone 30 mg (a potent narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 7/2/21, 7/3/21, 7/5/21, 7/6/21, 7/10/21, 7/11/21, 7/12/11, 7/13/21, 7/16/21, 7/17/21, 7/20/21, 7/24/21, 7/25/21 and 7/26/21. The "Controlled Drug Use Record" dated 7/22/21 through 7/26/21, indicated there was no Oxycodone 30 mg signed out on the narcotic sheet as being administered for the following dates at the scheduled time of 2 a.m. for the month of July 2021: 7/2/21, 7/3/21, 7/24/21, 7/25/21, and 7/26/21. The "Controlled Drug Use		times, twenty-four hours a day seven days a week. **<u>What date the systemic changes will be completed:</u>** **09/17/21** A CQI tool will be implemented on or before 09/17/2021 to ensure compliance is maintained. The Executive Director or Designee will review the Daily Nursing Schedule twice a month for a period of months 6 months. We respectfully request paper compliance for the alleged Deficiency.	

	Record" for the the dates of 7/4/21 to 7/22/21 was not located. LPN 7 indicated at that time, as she looked for the missing sheets that they must have been taken out the book and placed up somewhere to be filed in his chart. The "Daily Schedule Nursing" sheets dated July 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates did not have an "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.: 7/1/21, 7/2/21, 7/9/21, 7/10/21, 7/11/21, 7/12/21, 7/15/21, 7/16/21, 7/19/21, 7/23/21, 7/23/21, 7/25/21, and 7/26/21. During an interview on 7/26/21 at 4:45 p.m, the ED and LPN 2 were in attendance. LPN 2 indicated the night shifts Resident G was referring to when he indicated he had not received his medication was when there was no QMA scheduled to work. There were two QMA's who worked the night shift until one was let go approximately two weeks ago and they had not replaced her as of that date. The ED indicated the DONW (Director of Nursing and Wellness) typically was on call every night, but she was on vacation at that particular time and she would have placed a nurse to take call while she was off work. The ED indicated the "On Call Nurse"			

	name should have been listed on the "Daily Schedule Nursing" sheet to indicate which nurse was on call for the night shift if there was not a nurse scheduled for the night shift. The ED asked LPN 2 if the DONW left a call list to indicate who was on call while she was off on vacation. LPN 2 indicated the DONW did not assign any of the other facility nurses to be on call in her place while she was on vacation. LPN 2 did not realize Resident G had a medication ordered to be administered at 2:00 a.m. The ED indicated she was ultimately responsible for making sure there was someone on call available for the staff to call and to come into the facility to give medications as prescribed and needed. A current policy titled "Medication Administration Program Policy" dated 8/1/18, with a revision date of 6/15/18, provided by the ED on 7/26/21 at 4:30 p.m., indicated "Policy: Our community will provide medication assistance to residents who request assistance. This service is indicated on the Resident Service Plan and will be in compliance with the stat's administrative rules and regulations and orders from the physicians. Procedures: 1. Prior to medication assistance or administration, the community			

	will obtain prescribed medical authorization including one or more of the following:..b. A written order by the licensed prescriber...3. Residents receiving medication assistance will have:..b. Documentation of the medication name, dose, time taken by resident...4. Medication organizers will only be filled by qualified employees or the family member...The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program. The elements of an approved medication administration system are as follows:..2. Written policies related to medication assistance and administration are followed by licensed and unlicensed staff within their scope of practice...5. Documentation in the medication record is complete and accurate. a. Resident receives medications as prescribed...c. Medications record is correctly noted, with signatures and and explanations for missed medications noted properly. d. Medication is available to the resident in a correct and timely manner..." A current policy titled "Personnel-Deficiency 410IAC 16.2-5-1.4(b)" undated, provided by the ED on 7/26/21			

	at 4:45 p.m., indicated "(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications and training of staff shall depend on skills required to provide for the specific needs of the residents...." Based on interview and record review, the facility failed to ensure licensed and appropriately trained staff were available to provide ordered medications to 1 of 3 residents reviewed for care on the midnight shift (Resident G). Finding includes: During an interview on 7/26/21 at 2:49 p.m., Resident G indicated he had not been given his 2:00 a.m., dose of pain medication on several occasions due to there was no QMA (Qualified Medication Aide) or nurse scheduled to work on those night shifts when his medication was not given. He had not received his pain medication for the last three mornings because there was no licensed personnel available to give it to him. He asked his Physician if he could take the medication himself if the staff left the pill at his bedside prior to			

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	narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 6/2/2021, 6/3/21, 6/4/21, 6/18/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21. The "Controlled Drug Use Record" dated 5/26/21 through 6/11/21, indicated there was no Oxycodone 30 mg signed out on the narcotic sheet as being administered for the following dates at the scheduled time of 2 a.m. for the month of June 2021: 6/2/21, 6/3/21, 6/4/21, 6/5/21, 6/6/21, 6/12/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21. The resident's July 2021 EMAR (Electronic Medication Administration Record) was reviewed for the administration of his Oxycodone 30 mg (a potent narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 7/2/21, 7/3/21, 7/5/21, 7/6/21, 7/10/21, 7/11/21, 7/12/11, 7/13/21, 7/16/21, 7/17/21, 7/20/21,			

	7/24/21, 7/25/21 and 7/26/21. The "Controlled Drug Use Record" dated 7/22/21 through 7/26/21, indicated there was no Oxycodone 30 mg signed out on the narcotic sheet as being administered for the following dates at the scheduled time of 2 a.m. for the month of July 2021: 7/2/21, 7/3/21, 7/24/21, 7/25/21, and 7/26/21. The "Controlled Drug Use Record" for the the dates of 7/4/21 to 7/22/21 was not located. LPN 7 indicated at that time, as she looked for the missing sheets that they must have been taken out the book and placed up somewhere to be filed in his chart. The "Daily Schedule Nursing" sheets dated July 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates did not have an "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.: 7/1/21, 7/2/21, 7/9/21, 7/10/21, 7/11/21, 7/12/21, 7/15/21, 7/16/21, 7/19/21, 7/23/21, 7/23/21, 7/25/21, and 7/26/21. During an interview on 7/26/21 at 4:45 p.m, the ED and LPN 2 were in attendance. LPN 2 indicated the night shifts Resident G was referring to when he indicated he had not received his medication was when there was no QMA			

	scheduled to work. There were two QMA's who worked the night shift until one was let go approximately two weeks ago and they had not replaced her as of that date. The ED indicated the DONW (Director of Nursing and Wellness) typically was on call every night, but she was on vacation at that particular time and she would have placed a nurse to take call while she was off work. The ED indicated the "On Call Nurse" name should have been listed on the "Daily Schedule Nursing" sheet to indicate which nurse was on call for the night shift if there was not a nurse scheduled for the night shift. The ED asked LPN 2 if the DONW left a call list to indicate who was on call while she was off on vacation. LPN 2 indicated the DONW did not assign any of the other facility nurses to be on call in her place while she was on vacation. LPN 2 did not realize Resident G had a medication ordered to be administered at 2:00 a.m. The ED indicated she was ultimately responsible for making sure there was someone on call available for the staff to call and to come into the facility to give medications as prescribed and needed. A current policy titled "Medication Administration Program Policy" dated 8/1/18, with a revision date of 6/15/18,			

	provided by the ED on 7/26/21 at 4:30 p.m., indicated "Policy: Our community will provide medication assistance to residents who request assistance. This service is indicated on the Resident Service Plan and will be in compliance with the stat's administrative rules and regulations and orders from the physicians. Procedures: 1. Prior to medication assistance or administration, the community will obtain prescribed medical authorization including one or more of the following:..b. A written order by the licensed prescriber...3. Residents receiving medication assistance will have:..b. Documentation of the medication name, dose, time taken by resident...4. Medication organizers will only be filled by qualified employees or the family member...The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program. The elements of an approved medication administration system are as follows:..2. Written policies related to medication assistance and administration are followed by licensed and unlicensed staff within their scope of practice...5. Documentation in the medication record is complete and accurate. a. Resident			

	receives medications as prescribed...c. Medications record is correctly noted, with signatures and and explanations for missed medications noted properly. d. Medication is available to the resident in a correct and timely manner..." A current policy titled "Personnel-Deficiency 410IAC 16.2-5-1.4(b)" undated, provided by the ED on 7/26/21 at 4:45 p.m., indicated "(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications and training of staff shall depend on skills required to provide for the specific needs of the residents...."			
R 0248	Health Services - Deficiency 410 IAC 16.2-5-4(f) (f) The facility shall have available on the premises or on call the services of a licensed nurse at all times. Based on interview and record review, the facility failed to ensure the services of a licensed nurse were available at all times for 1 of 3 residents	R 0248	**Tag; Title; Deficiency or Offense:** **R 248** **Health Services – Deficiency** **The facility shall have available on**	09/17/2021

	reviewed for night care services (Resident G). Finding includes: During an interview on 7/26/21 at 4:45 p.m., the Executive Director (ED) and Licensed Practical Nurse (LPN) 2 were in attendance. LPN 2 indicated the night shifts Resident G had not received his medication were when there was no Qualified Medication Aide (QMA) scheduled to work. There were two QMA's who worked the night shift until one was let go approximately two weeks ago and they had not replaced her as of that date. The ED indicated the DONW (Director of Nursing and Wellness) typically was on call every night, but she was on vacation at that particular time, and she would have placed a nurse to take call while she was off work. The ED indicated the "On Call Nurse" name should have been listed on the "Daily Schedule Nursing" sheet to indicate which nurse was on call for the night shift if there was not a nurse scheduled for the night shift. The ED asked LPN 2 if the DONW left a call list to indicate who was on call while she was off on vacation. LPN 2 indicated the DONW had not assigned any of the other facility nurses to be on call in her place while she was on vacation. LPN 2 did not realize Resident G had a		**the premises or on call the services of a licensed nurse at all times.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** The Executive Director, Director of Nursing and Wellness or the Designee to ensure a licensed nurse is available on the premises and/or on call at all times. **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;**	

	medication ordered to be administered at 2:00 a.m. The ED indicated she was ultimately responsible for making sure there was someone on call available for the staff to call and to come into the facility to give medications as prescribed and needed. During an interview on 7/26/21 at 2:49 p.m., Resident G indicated he had not been given his 2:00 a.m., dose of pain medication on several occasions due to there was no QMA (Qualified Medication Aide) or nurse scheduled to work on those night shifts when his medication was not given. He had not received his pain medication for the last three mornings because there was no licensed personnel available to give it to him. He asked his Physician if he could take the medication himself if the staff left the pill at his bedside prior to them leaving on the afternoon shift and his Physician indicated he was not going to write the order for him to administer his medication because the facility was supposed to be responsible for administering his medications. During an interview on 7/26/21 at 3:30 p.m., LPN 2 and LPN 7 were in attendance. LPN 7 indicated she did not realize Resident G had a medication ordered to be administered at		Residents of the community receiving medication services have the potential to be affected by the alleged Deficiency. Executive Director or Designee to ensure the daily nursing schedule lists the name of the licensed nurse available on the premises and/or on call at all times. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** Executive Director or Designee to ensure the daily nursing schedule form lists, the name and contact information of the licensed nurse available on the premises and/or on call at all times. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place;**	

	2:00 a.m. All the residents who had medications scheduled on the night shift, were given those medications prior to the evening shift leaving, then the residents administered the medications to themselves at the times they were due to be given . Resident G was not a candidate to self-administer his own medications, so he had to have his medication at 2:00 a.m., administered by a nurse or a QMA. Resident G's record was reviewed on 7/26/21 at 4:30 p.m. Diagnoses included, but were not limited to, heart failure, muscle spasms, chronic kidney disease and type 2 Diabetes Mellitus. The resident's June 2021 EMAR (Electronic Medication Administration Record) was reviewed for the administration of his Oxycodone 30 (a potent narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 6/2/2021, 6/3/21, 6/4/21, 6/18/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21. The "Controlled Drug Use Record" dated 5/26/21 through 6/11/21, indicated there was no		The Executive Director or Designee to revise the Daily Nursing Schedule form, on or before 09/01/2021, to reflect the name and contact information of the Licensed Nurse available on the premises and/or on call at all times, twenty-four hours a day, seven days a week. **<u>What date the systemic changes will be completed:</u> 09/17/2021** A CQI tool will be implemented on or before 09/17/2021 to ensure compliance is maintained. The Executive Director or Designee will review the Daily Nursing Schedule twice a month for a period of months 6 months. We respectfully request a paper compliance for the alleged Deficiency.	

Oxycodone 30 mg given for the following dates at the scheduled time of 2 a.m. for the month of June 2021: 6/2/21, 6/3/21, 6/4/21, 6/5/21, 6/6/21, 6/12/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21.

The "Daily Schedule Nursing" sheets dated June 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates had a QMA scheduled "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.:

6/26/21--QMA 8 was scheduled

6/27/21--QMA 8 was scheduled

6/28/21--QMA 8 was scheduled

6/29/21--QMA 9 was scheduled

6/30/21--QMA 9 was scheduled

The resident's July 2021 EMAR (Electronic Medication Administration Record) was reviewed for the administration of his Oxycodone 30 mg (a potent narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 7/2/21, 7/3/21, 7/5/21, 7/6/21, 7/10/21, 7/11/21, 7/12/11, 7/13/21, 7/16/21, 7/17/21, 7/20/21,

7/24/21, 7/25/21 and 7/26/21.

The "Controlled Drug Use Record" for the dates of 7/4/21 to 7/22/21 was not located. LPN 7 indicated at that time, as she looked for the missing sheets that they must have been taken out the book and placed up somewhere to be filed in his chart.

The "Controlled Drug Use Record," dated 7/22/21 through 7/26/21, indicated there was no Oxycodone 30 mg given for the following dates at the scheduled time of 2 a.m. for the month of July 2021: 7/2/21, 7/3/21, 7/24/21, 7/25/21, and 7/26/21.

The "Daily Schedule Nursing" sheets dated July 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates did not have an "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.: 7/1/21, 7/2/21, 7/9/21, 7/10/21, 7/11/21, 7/12/21, 7/15/21, 7/16/21, 7/19/21, 7/23/21, 7/23/21, 7/25/21, and 7/26/21.

The "Daily Schedule Nursing" sheets dated July 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates had a QMA scheduled "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.:

07/03/21--QMA 9 was scheduled

07/04/21--QMA 9 was scheduled

07/05/21--QMA 8 was scheduled

07/06/21--QMA 9 was scheduled

07/07/21--QMA 9 was scheduled

07/08/21--QMA 9 was scheduled

07/13/21--QMA 9 was scheduled

07/13/21--QMA 9 was scheduled

07/17/21--QMA 9 was scheduled

07/18/21--QMA 9 was scheduled

07/20/21--QMA 9 was scheduled

07/21/21--QMA 9 was scheduled

07/22/21--QMA 9 was scheduled

A current policy titled "Medication Administration Program Policy" dated 8/1/18, with a revision date of 6/15/18, provided by the ED on 7/26/21 at 4:30 p.m., indicated "Policy: Our community will provide medication assistance to

residents who request assistance. This service is indicated on the Resident Service Plan and will be in compliance with the stat's administrative rules and regulations and orders from the physicians. Procedure...The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program. The elements of an approved medication administration system are as follows...2. Written policies related to medication assistance and administration are followed by licensed and unlicensed staff within their scope of practice...5. Documentation in the medication record is complete and accurate. a. Resident receives medications as prescribed...c. Medications record is correctly noted, with signatures and explanations for missed medications noted properly. d. Medication is available to the resident in a correct and timely manner..."

A current policy titled "Personnel-Deficiency 410IAC 16.2-5-1.4(b)" undated, provided by the ED on 7/26/21 at 4:45 p.m., indicated " ...(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules

to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications and training of staff shall depend on skills required to provide for the specific needs of the residents...."

Based on interview and record review, the facility failed to ensure the services of a licensed nurse were available at all times for 1 of 3 residents reviewed for night care services (Resident G).

Finding includes:

During an interview on 7/26/21 at 4:45 p.m., the Executive Director (ED) and Licensed Practical Nurse (LPN) 2 were in attendance. LPN 2 indicated the night shifts Resident G had not received his medication were when there was no Qualified Medication Aide (QMA) scheduled to work. There were two QMA's who worked the night shift until one was let go approximately two weeks ago and they had not replaced her as of that date. The ED indicated the DONW (Director of Nursing and Wellness) typically was on call every night, but she was on vacation at that particular time, and she would have placed a nurse to take call while she was off work. The ED indicated the "On Call Nurse"

name should have been listed on the "Daily Schedule Nursing" sheet to indicate which nurse was on call for the night shift if there was not a nurse scheduled for the night shift. The ED asked LPN 2 if the DONW left a call list to indicate who was on call while she was off on vacation. LPN 2 indicated the DONW had not assigned any of the other facility nurses to be on call in her place while she was on vacation. LPN 2 did not realize Resident G had a medication ordered to be administered at 2:00 a.m. The ED indicated she was ultimately responsible for making sure there was someone on call available for the staff to call and to come into the facility to give medications as prescribed and needed.

During an interview on 7/26/21 at 2:49 p.m., Resident G indicated he had not been given his 2:00 a.m., dose of pain medication on several occasions due to there was no QMA (Qualified Medication Aide) or nurse scheduled to work on those night shifts when his medication was not given. He had not received his pain medication for the last three mornings because there was no licensed personnel available to give it to him. He asked his Physician if he could take the medication himself if the staff left the pill at his bedside prior to

them leaving on the afternoon shift and his Physician indicated he was not going to write the order for him to administer his medication because the facility was supposed to be responsible for administering his medications.

During an interview on 7/26/21 at 3:30 p.m., LPN 2 and LPN 7 were in attendance. LPN 7 indicated she did not realize Resident G had a medication ordered to be administered at 2:00 a.m. All the residents who had medications scheduled on the night shift, were given those medications prior to the evening shift leaving, then the residents administered the medications to themselves at the times they were due to be given . Resident G was not a candidate to self-administer his own medications, so he had to have his medication at 2:00 a.m., administered by a nurse or a QMA.

Resident G's record was reviewed on 7/26/21 at 4:30 p.m. Diagnoses included, but were not limited to, heart failure, muscle spasms, chronic kidney disease and type 2 Diabetes Mellitus.

The resident's June 2021 EMAR (Electronic Medication Administration Record) was reviewed for the administration of his Oxycodone 30 (a potent

narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 6/2/2021, 6/3/21, 6/4/21, 6/18/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21.

The "Controlled Drug Use Record" dated 5/26/21 through 6/11/21, indicated there was no Oxycodone 30 mg given for the following dates at the scheduled time of 2 a.m. for the month of June 2021: 6/2/21, 6/3/21, 6/4/21, 6/5/21, 6/6/21, 6/12/21, 6/18/21, 6/19/21, 6/24/21, 6/25/21, 6/26/21, and 6/27/21.

The "Daily Schedule Nursing" sheets dated June 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates had a QMA scheduled "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.:

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6/29/21--QMA 9 was scheduled

6/30/21--QMA 9 was scheduled

The resident's July 2021 EMAR (Electronic Medication Administration Record) was

reviewed for the administration of his Oxycodone 30 mg (a potent narcotic pain medication). The following dates were days with no initials marked on the EMAR, which indicated the resident did not receive his regularly scheduled 2:00 a.m., dose of Oxycodone for the following dates: 7/2/21, 7/3/21, 7/5/21, 7/6/21, 7/10/21, 7/11/21, 7/12/11, 7/13/21, 7/16/21, 7/17/21, 7/20/21,

7/24/21, 7/25/21 and 7/26/21.

The "Controlled Drug Use Record" for the dates of 7/4/21 to 7/22/21 was not located. LPN 7 indicated at that time, as she looked for the missing sheets that they must have been taken out the book and placed up somewhere to be filed in his chart.

The "Controlled Drug Use Record," dated 7/22/21 through 7/26/21, indicated there was no Oxycodone 30 mg given for the following dates at the scheduled time of 2 a.m. for the month of July 2021: 7/2/21, 7/3/21, 7/24/21, 7/25/21, and 7/26/21.

The "Daily Schedule Nursing" sheets dated July 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates did not have an "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.: 7/1/21, 7/2/21, 7/9/21, 7/10/21, 7/11/21,

7/12/21, 7/15/21, 7/16/21, 7/19/21, 7/23/21, 7/23/21, 7/25/21, and 7/26/21.

The "Daily Schedule Nursing" sheets dated July 2021 were reviewed with the ED, LPN 2 and LPN 7. The following dates had a QMA scheduled "On Call Nurse" listed as being on call from 11:00 p.m., to 7:00 p.m.:

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07/06/21--QMA 9 was scheduled

07/07/21--QMA 9 was scheduled

07/08/21--QMA 9 was scheduled

07/13/21--QMA 9 was scheduled

07/13/21--QMA 9 was scheduled

07/17/21--QMA 9 was scheduled

07/18/21--QMA 9 was scheduled

07/20/21--QMA 9 was scheduled

07/21/21--QMA 9 was scheduled

07/22/21--QMA 9 was scheduled

A current policy titled "Medication Administration Program Policy" dated 8/1/18, with a revision date of 6/15/18, provided by the ED on 7/26/21 at 4:30 p.m., indicated "Policy: Our community will provide medication assistance to residents who request assistance. This service is indicated on the Resident Service Plan and will be in compliance with the stat's administrative rules and regulations and orders from the physicians. Procedure...The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program. The elements of an approved medication administration system are as follows...2. Written policies related to medication assistance and administration are followed by licensed and unlicensed staff within their scope of practice...5. Documentation in the medication record is complete and accurate. a. Resident receives medications as prescribed...c. Medications record is correctly noted, with signatures and explanations for

	missed medications noted properly. d. Medication is available to the resident in a correct and timely manner..." A current policy titled "Personnel-Deficiency 410IAC 16.2-5-1.4(b)" undated, provided by the ED on 7/26/21 at 4:45 p.m., indicated " ...(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications and training of staff shall depend on skills required to provide for the specific needs of the residents...."			

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