STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/12/2021

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 IN00357191 and IN00357605. Complaint IN00357191 - Substantiated. State deficiencies related to the allegations were cited at R241, R244 and R306 . Complaint IN00357605 - Substantiated. State deficiencies related to the allegations were cited at R241, R244 and R306. Unrelated deficiencies are cited at R064. Survey dates: July 9 and 12, 2021 Facility number: 014137 Residential Census: 114 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5. Quality review was completed	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,	

	on July 19, 2021.		HFA, RCA, CNA Executive Director	
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss 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 interview and record review, the facility failed to ensure a residents' narcotic medication was kept safe and secure during her admission for 1 of 10 residents being reviewed for misappropriation of property (Resident E). Finding includes: A undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated on 4/22/21 on the dayshift, Resident E's Fentanyl patch (a narcotic medication used to control high levels of pain) 25 mcg (micrograms) was removed by QMA 7 and a new patch was placed. The administration of a new Fentanyl patch was a medication error related to QMA 7 placed the	R 0064	**Tag;** **Title; Deficiency or Offense:** **R 064 Residents' Rights – Noncompliance** **The facility shall exercise reasonable care for the protection of residents' property from loss and theft. The administration 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.** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Executive Director or Designee to exercise reasonable care for the protection of residents' property from loss and theft and shall be responsible for investigating reports of lost or stolen resident property and report results of investigation findings to the resident or responsible	08/30/2021

	new patch on Resident E on the wrong date and shift. The resident's physician wrote a new order for an extra patch, the facility covered the cost of the patch and the new patch was applied on 4/23/21, on the evening shift as ordered. The facility nurses and QMAs were in-serviced on 4/28/21, over the six rights of administering medication. The agency company QMA 7 worked for was notified and she was placed on a "Do Not Return to the Facility" list and she would not be allowed back into the facility to care for residents. Resident E's record was reviewed on 7/12/21 at 4:45 p.m. The diagnoses included, but were not limited to, chronic pain, mild cognitive impairment, hypotension and major depressive disorder. The Electronic Medication Administration Record (EMAR), dated April 2021, included, but was not limited to, the following order:		party. **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;** The residents of the community have the potential to be affected by the alleged Noncompliance. Community RN, LPN and QMA will be provided re-education, within each disciplines scope of care, on proper destruction of narcotic medication on or before 08/30/2021, by the Director of Health and Wellness. **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 maintain and audit narcotic destruction log book in order to identify loss or theft of resident property and to investigate reports of lost or stolen resident	

	Fentanyl Patch 72 hour 25 mcg/hr apply one patch transdermally (apply to the skin) every 72 hours for pain and remove according to the ordered schedule every 72 hours. The patch was scheduled to be removed at 5:29 p.m., and a new patch applied at 5:30 p.m. Resident E's EMAR for this medication indicated it was changed on 4/20/21 at 6:00 p.m., then changed on 4/23/21 at 5:29 p.m. The progress notes and EMAR were reviewed and no documentation was found, which indicated QMA 7 documented Resident E's Fentanyl patch change or the destruction of the patch she removed from 4/22/21. During an interview, on 7/12/21 at 2:00 p.m., the DON indicated on 4/22/21, QMA 7 changed a newly applied Fentanyl patch (the patch was applied the day prior) on Resident E. When asked why she applied a new patch prior to the date ordered, QMA 7 indicated she read the date on the EMAR wrong. The DON indicated she committed a medication error because she did not follow the policy and procedures for administering the medication and she did not dispose of the used Fentanyl patch according to their policy		property, reporting the finding to resident or responsible party upon conclusion of investigation. **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;** A CQI monitoring tool will be implemented on or before 08/16/2021 to ensure compliance is maintained. The Executive Director or Designee will monitor daily for 2 weeks; weekly for 4 weeks; then monthly until compliance is maintained consecutively for 3 months or until the Quality Assurance Committee finds compliance has been met and/or makes further recommendations are made. **What date the systemic changes will be completed:** **08/30/2021** **We respectfully request a paper compliance for the alleged Noncompliance.**	

	either. There were supposed to be two nurses or one nurse and a QMA destroy narcotics and QMA 7 indicated she wasted the Fentanyl patch by herself, without an explanation as to why she did not have a witness to destroy the patch with her. QMA 7 was placed on the agency DNR (Do Not Return to the facility) list due to the suspicion of drug diversion. A current policy, titled "Medication Administration Program Policy," dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...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. b. Subscriber's orders for discontinued medications are maintained. c. Medication 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. 6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...." A current policy, titled "Medication Disposal Policy," with a revision date of 8/11/18, indicated "Policy: Discontinued medications must be removed from the medication cart and disposed of according to state and federal regulations and following procedures established by community consulting pharmacy. Procedures: Disposal of outdated, discontinued, recalled medications shall occur no longer than seven days after the discontinuation. Disposal of all			

	controlled medications is accomplished by one of the following methods: pouring into a dissolving medication solution, coffee grounds, kitty litter or destruction by cutting in small pieces and placing in the drug buster and witnessed by the Executive Director/Director of Health and Wellness or another facility employee approved by the Executive Director/Direct tor of Health and Wellness to perform this function. For all types of medications, a Drug Disposal Record must be completed which includes the following information: 1. Name of medication 2. Remaining amount of medication being disposed 3. Resident name 4. Reason of disposal 5. Method of disposal 6. Date of Disposal 7. Signature of the two witnesses disposing of the medication. Controlled medications require additional documentation when disposal takes place. A Narcotic Count Sheet (in addition to the Drug Disposal record) is also signed by the two witnesses, verifying the number of medications being disposed, date and why medication is discontinued. Disposal of non-controlled medications may be performed by two Qualified Medication Aides. Based on interview and record review, the facility failed to			

	ensure a residents' narcotic medication was kept safe and secure during her admission for 1 of 10 residents being reviewed for misappropriation of property (Resident E). Finding includes: A undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated on 4/22/21 on the dayshift, Resident E's Fentanyl patch (a narcotic medication used to control high levels of pain) 25 mcg (micrograms) was removed by QMA 7 and a new patch was placed. The administration of a new Fentanyl patch was a medication error related to QMA 7 placed the new patch on Resident E on the wrong date and shift. The resident's physician wrote a new order for an extra patch, the facility covered the cost of the patch and the new patch was applied on 4/23/21, on the evening shift as ordered. The facility nurses and QMAs were in-serviced on 4/28/21, over the six rights of administering medication. The agency company QMA 7 worked for was notified and she was placed on a "Do Not Return to the Facility" list and she would not be allowed back into the facility to care for residents. Resident E's record was			

reviewed on 7/12/21 at 4:45 p.m. The diagnoses included, but were not limited to, chronic pain, mild cognitive impairment, hypotension and major depressive disorder.

The Electronic Medication Administration Record (EMAR), dated April 2021, included, but was not limited to, the following order:

Fentanyl Patch 72 hour 25 mcg/hr apply one patch transdermally (apply to the skin) every 72 hours for pain and remove according to the ordered schedule every 72 hours. The patch was scheduled to be removed at 5:29 p.m., and a new patch applied at 5:30 p.m.

Resident E's EMAR for this medication indicated it was changed on 4/20/21 at 6:00 p.m., then changed on 4/23/21 at 5:29 p.m.

The progress notes and EMAR were reviewed and no documentation was found, which indicated QMA 7 documented Resident E's Fentanyl patch change or the destruction of the patch she removed from 4/22/21.

During an interview, on 7/12/21 at 2:00 p.m., the DON indicated on 4/22/21, QMA 7 changed a newly applied Fentanyl patch (the patch was applied the day

	prior) on Resident E. When asked why she applied a new patch prior to the date ordered, QMA 7 indicated she read the date on the EMAR wrong. The DON indicated she committed a medication error because she did not follow the policy and procedures for administering the medication and she did not dispose of the used Fentanyl patch according to their policy either. There were supposed to be two nurses or one nurse and a QMA destroy narcotics and QMA 7 indicated she wasted the Fentanyl patch by herself, without an explanation as to why she did not have a witness to destroy the patch with her. QMA 7 was placed on the agency DNR (Do Not Return to the facility) list due to the suspicion of drug diversion. A current policy, titled "Medication Administration Program Policy," dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...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. b. Subscriber's orders for discontinued medications are maintained. c. Medication 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. 6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...." A current policy, titled "Medication Disposal Policy," with a revision date of 8/11/18, indicated "Policy: Discontinued			

	medications must be removed from the medication cart and disposed of according to state and federal regulations and following procedures established by community consulting pharmacy. Procedures: Disposal of outdated, discontinued, recalled medications shall occur no longer than seven days after the discontinuation. Disposal of all controlled medications is accomplished by one of the following methods: pouring into a dissolving medication solution, coffee grounds, kitty litter or destruction by cutting in small pieces and placing in the drug buster and witnessed by the Executive Director/Director of Health and Wellness or another facility employee approved by the Executive Director/Direct tor of Health and Wellness to perform this function. For all types of medications, a Drug Disposal Record must be completed which includes the following information: 1. Name of medication 2. Remaining amount of medication being disposed 3. Resident name 4. Reason of disposal 5. Method of disposal 6. Date of Disposal 7. Signature of the two witnesses disposing of the medication. Controlled medications require additional documentation when disposal takes place. A Narcotic Count Sheet (in addition to the Drug			

	Disposal record) is also signed by the two witnesses, verifying the number of medications being disposed, date and why medication is discontinued. Disposal of non-controlled medications may be performed by two Qualified Medication Aides.			
R 0241	Health Services - Offense 410 IAC 16.2-5-4(e)(1) (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure residents' medications were administered as ordered by the physician, related to medications were given to the wrong resident, omitted medications, a narcotic patch was removed prior to the due date and extra medication doses were given for 5 of 10 residents reviewed for medication administration (Residents B, C, D, E and F). This deficit practice resulted in a QMA (Qualified Medication	R 0241	**Tag; Title; Deficiency or Offense:** **R 241** **Health Services – Offense** **What corrective action will be accomplished for those residents found to have been affected by the offence;** The Executive Director, Director of Nursing and Wellness or Designee to perform random observation audits during medication pass of nursing staff for quality control and compliance. **How the facility will identify other residents**	08/30/2021

	Aide) 4 committing a medication error which resulted in Resident B having an adverse reaction of hypotension (low blood pressure), an altered mental status (a change in the resident's mental condition) and she was admitted to an ICU (Intensive Care Unit) at a hospital to monitor her blood pressure overnight. Findings include: 1. A document, titled "Indiana State Department of Health Survey Report System," dated 7/1/21, was provided by the DON (Director of Nursing) on 7/9/21 at 5:00 p.m. This document indicated QMA 4 committed a medication error on 6/30/21 at 8:01 p.m., while administering Resident B's evening medications to her and the resident was admitted to a hospital ICU overnight for monitoring of her low BP (blood pressure) and mental status change. Resident B's record was reviewed on 7/12/21 at 12:45 p.m. The diagnoses included, but were not limited to, paranoid schizophrenia, major depressive disorder, diabetes mellitus, bipolar disorder and anxiety disorder. The progress notes included, but were not limited to, the following:		**having the potential to be affected by the same deficient practice and what corrective action will be taken;** The residents of the community receiving medication from nursing staff have the potential to be affected by the alleged offense. Nursing staff In-Service on the 5 Rights of Medication Administration will be required of nursing staff on or before 08/30/2021. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;**	

	On 6/30/21 at 8:50 p.m., the note indicated a QMA gave a medication error to Resident B, then the QMA notified the DON, who overseen the assessment. Resident B's BP was 104/68 at the time of the occurrence of the medication error. The resident's new BP was 86/60 at the time when the physician was notified of the medication error and the resident was sent to the ER for evaluation and treatment. On 7/1/21 at 7:22 a.m., the note indicated the DON received a phone call from a QMA at 7:30 p.m., indicating she had given Resident B the wrong medication. The DON had the QMA list all the medications the resident received in error. BP at that time was 104/78. On 7/1/21 at 7:23 a.m., the note indicated the DON received a phone call from the QMA. The resident's BP continued to drop at that time, the QMA was instructed to call 911 and the resident was sent to the ER. On 7/1/21 at 9:28 a.m., the note indicated Resident B remained at the hospital. A document, titled "Medication Error Report," dated 7/1/21, indicated a medication error was committed on 6/30/21 at 7:30 p.m., by a QMA. The QMA administered the wrong medication to Resident B and		The Executive Director, the Director of Nursing and Wellness or the Designee to observe and monitor medication administration and have oversite for medication errors to ensure proper policy and procedure were followed and were in accordance with State and Local Law. **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;** A CQI monitoring tool will be implemented on 08/16/21 to ensure compliance; the Executive Director or Designee will monitor daily for 2 weeks; weekly for 4 weeks; then monthly until compliance is maintained consecutively for 3 months or until the Quality Assurance Committee finds compliance has been met and/or further recommendations are made. **What date the systemic changes will be completed:**	

	omitted this resident's regularly scheduled medication. The resident was sent to the ER (Emergency Room) for evaluation and treatment due to her BP was dropping, then she was admitted to the hospital to the ICU (Intensive Care Unit) for monitoring overnight. This QMA was suspended while an investigation was completed. The following listed medications were the medications QMA 4 administered to Resident B instead of her routinely scheduled medications for evening and bedtime on 6/30/21. Atorvastatin (a medication used to treat high cholesterol) 80 mg. Apixabar (a medication used to thin the blood to treat blood clots) 5 mg. Norco (a narcotic medication used to treat pain) 5/325 mg. Motorola (a medication used to treat high blood pressure and heart disease) 25 mg. Tizanidine (a medication used to treat muscle cramps) 2 mg. A document, dated 7/1/21 at 2:00 p.m., was provided by the DON on 7/9/21 at 5:00 p.m. The ED (Executive Director) signed her name to this document indicating this was the statement from QMA (Qualified Medication Aide) 4, who		**08/30/21** We respectfully request paper compliance for the alleged Offense.	

	indicated in this statement she had pre-set three resident's medications and Resident B was the resident who was given the wrong medication. QMA 4 indicated in this statement, she pre-set three residents' medications, then she went to administer those medications. When she went to administer Resident B and her husband's medications to them, she gave Resident B the medications for the resident who lived across the hallway from her. QMA 4 realized she gave Resident B the wrong medication when she walked out of her apartment and looked down at the pill cup in her hand. A document, untitled, dated 7/2/21, was provided by the DON on 7/9/21 at 5:00 p.m. The document indicated QMA 4 met with the ED and DON regarding the investigation of the medication error for Resident B. During the interview, QMA 4 indicated she had pre-set medications for three residents, which resulted in a medication error with an adverse reaction, resulting in a hospitalization for Resident B. QMA 4 was terminated based on the "harmful medication error, resulting in hospitalization." During an interview, on 7/9/21 at 3:34 p.m., the DON indicated QMA 4 wrote a statement indicating she "caused" the			

	medication error on 6/30/21 with Resident B. She had pre-set three different residents' medications and she gave Resident B the medications for the resident who lived across the hallway from her. QMA 4 was suspended during the investigation of the medication error, then she was terminated once the ED and DON received her written statement indicating she had pre-set her medications. The DON indicated prior to starting her shift on 6/30/21, QMA 4 attended an in-service related to pre-setting medications and causing injury to residents when staff pre-set medications. A document, titled "Medication Administration Inservice," dated 6/30/21, was provided by the DON on 7/9/21 at 5:00 p.m. The in-service document was signed by QMA 4 indicating she was at the in-service. The material discussed during the in-service included, but was not limited to, the following information: Six rights to medication administration, always do three checks with medication administration and never preset medications. 2. Resident C's record was reviewed on 7/12/21 at 1:07 p.m. The diagnoses included, but were not limited to, Parkinson's Disease, Bipolar Disorder, unspecified			

convulsions and anxiety disorder.

A document, titled "Level of Service Assessment/Evaluation-Full List of Items-Assisted Living," dated 6/24/21 indicated her medication service plan indicated she did not know the name, reason or time of her medications, and she would receive medications, insulin and glucometer checks from staff and be supported to take all medications safely and as ordered.

The Electronic Medication Administration Record (EMAR), dated June 2021, included, but was not limited to, the following physician's order:

Clonazepam (a medication used to treat anxiety) 0.5 mg give one tablet two times a day for anxiety-scheduled to be given at 9:00 a.m. and 5:00 p.m. (On 6/29/21 both times were initialed indicating the resident received this medication at the scheduled times.

A document, titled "Controlled Drug Use Record," dated 6/27/21 through 7/5/21, indicated on 6/29/21, Resident C received his Clonazepam 0.5 mg on the following times 8:00 a.m., 5:00 p.m. and 8:23 p.m.

The progress notes and physician's orders were

	reviewed and no documentation was found to indicate Resident C should have received an extra dose of Clonazepam on 6/29/21 at 8:23 p.m. During an interview, on 7/12/21 at 2:00 p.m., when the DON was asked about three doses of Clonazepam 0.5 mg being given on 6/29/21 instead of two doses being given, she indicated she would have to ask if there was an extra dose given or not. During an interview, on 7/12/21 at 3:50 p.m., the DON indicated there was not an order for Resident C to have an extra Clonazepam on 6/29/21 at 8:30 p.m., so the dose was a medication error. The medication administration times for the medication should have been 9:00 a.m. and 5:00 p.m. 3. An undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated Resident D received the wrong dosage of Clonazepam on 5/31/21 at 8:20 p.m. The wrong resident's medication card with the wrong dosage was pulled and Resident D received 0.5 mg of Clonazepam instead of 0.25 mg. No adverse reaction occurred from this medication error. The staff member was given education on slowing down and doing the six medication rights			

when administering medication to residents.

Resident D's record was reviewed on 7/12/21 at 3:38 p.m. The diagnoses included, but were not limited to, superjacent tachycardia, alcohol abuse and aphasia following a cerebral infarction.

The Electronic Medication Administration Record (EMAR), dated May 2021, included, but was not limited to, the following order:

Clonazepam Tablet 0.5 mg, give 0.25 mg (1/2 tablet of a 0.5 mg tablet) by mouth two times a day related to anxiety disorder-scheduled for 7:00 a.m. and 7:00 p.m.

A document, titled "Controlled Drug Use Record," dated 5/10/21 through 6/5/21, had documentation which indicated on 5/17/21, Resident D received a Clonazepam 0.25 mg dose at 8:00 a.m., 7:00 p.m. and 7:20 p.m.

The progress notes and physician's orders were reviewed and no documentation was found to indicate Resident D should have received the extra dose of Clonazepam on 5/17/21 at 7:20 p.m.

A progress note, dated 5/31/21 at 10:22 p.m., indicated Resident D had an order for

	Clonazepam 0.5 mg tablet for anxiety disorder, he was supposed to be administered 0.25 mg by mouth two times per day. The order was written as to give 1/2 tablet of a 0.5 mg Clonazepam tablet twice daily. The resident's medication was in the narcotic box with another resident's medications and the QMA administering his medications pulled a card and read the label too quickly. When she read the label of Resident L's Clonazepam card of 0.5 mg she pushed the pill out into a medicine cup and administered it to Resident D at approximately 6:30 p.m. Then around 8:00 p.m., when the QMA was ready to count the narcotic box for the cart, she realized Resident L had a Clonazepam Disintegrated tablet 0.5 mg missing. This was when, she realized she administered the missing Clonazepam disintegrated 0.5 mg tablet to Resident D and she had made a medication error. The resident was monitored and no adverse reactions occurred from this medication error. During an interview, on 7/12/21 at 2:00 p.m., the DON indicated QMA 6 pulled Resident L's Clonazepam 0.5 mg card from the narcotic box and punched out one pill instead of pulling Resident D's card from the narcotic box. The narcotic cards in the narcotic box were not			

	alphabetized and Resident L's Clonazepam card was right in front of Resident D's Clonazepam card and since both residents names were similar, Resident L's Clonazepam card was used instead of Resident D's card. During an interview, on 7/12/21 at 4:35 p.m., the DON was asked about Resident D receiving an extra dose of Clonazepam on 5/17/21 at 7:20 p.m., she indicated she did not know why he received an extra dose of Clonazepam that day because he should have only received it twice as ordered. His second dose for the day was scheduled for 7:00 p.m., which was at the change of shift, so the day shift person may have administered it and forgotten to document the medication as given in the EMAR, but signed it out on the narcotic sheet. Since the day shift staff member might not have documented it in the EMAR as given then it would stay "popped up" (lit up on the computer screen to indicate it was time for the medication to be administered) for the next staff member and this may have been why she gave the extra dose, which would make three doses given in a 24 hour period a medication error. 4. A undated document, titled "Medication Error Report," was provided by the DON on 7/9/21			

	at 4:45 p.m. This document indicated on 4/22/21 on the dayshift, Resident E's Fentanyl patch (a narcotic medication used to control high levels of pain) 25 mcg (micrograms) was removed by QMA 7 and a new patch was placed. The administration of a new Fentanyl patch was a medication error related to QMA 7 placed the new patch on Resident E on the wrong date and shift. The resident's physician wrote a new order for an extra patch, the facility covered the cost of the patch and the new patch was applied on 4/23/21, on the evening shift as ordered. The facility nurses and QMAs were in-serviced on 4/28/21, over the six rights of administering medication. The agency company QMA 7 worked for was notified and she was placed on a "Do Not Return to the Facility" list and she would not be allowed back into the facility to care for residents. Resident E's record was reviewed on 7/12/21 at 4:45 p.m. The diagnoses included, but were not limited to, chronic pain, mild cognitive impairment, hypotension and major depressive disorder.			

	The Electronic Medication Administration Record (EMAR), dated April 2021, included, but was not limited to, the following order: Fentanyl Patch 72 hour 25 mcg/hr apply one patch transdermally (apply to the skin) every 72 hours for pain and remove according to the ordered schedule every 72 hours. The patch was scheduled to be removed at 5:29 p.m., and a new patch applied at 5:30 p.m. Resident E's EMAR for this medication indicated it was changed on 4/20/21 at 6:00 p.m., then changed on 4/23/21 at 5:29 p.m. A progress note, dated 4/23/21 at 3:47 p.m., indicated a medication error was discovered with Resident E's Fentanyl Patch administration on 4/22/21. An order for one extra Fentanyl patch was written by the Physician, which will be taken from the EDK (Emergency Drug Kit), then the facility will pay for the extra patch. The progress notes and EMAR were reviewed and no documentation was found, which indicated QMA 7 documented Resident E's Fentanyl patch change or the destruction of the patch she removed from 4/22/21.			

	A document, titled "Pharmacy Communication Memo," dated 4/28/21, from the facility pharmacy indicated Resident E's Fentanyl Patch 25 mcg/hr (hour) was ordered too soon. The date of the last fill was 4/5/21 and the next fill will be sent on 4/29/21. The "Notes" section indicated this item was not covered by the resident's insurance until 4/29/21, due to it was filled at another pharmacy on 4/5/21. The facility's action to be taken indicated there was a medication error committed and the resident was one patch short and the facility would guarantee payment for the Fentanyl patch being ordered on 4/28/21. During an interview, on 7/12/21 at 2:00 p.m., the DON indicated on 4/22/21, QMA 7 changed a newly applied Fentanyl patch (the patch was applied the day prior) on Resident E. When asked why she applied a new patch prior to the date ordered, QMA 7 indicated she read the date on the EMAR wrong. The DON indicated she committed a medication error because she did not follow the policy and procedures for administering the medication and she did not dispose of the used Fentanyl patch according to their policy either. There were supposed to be two nurses or one nurse and a QMA destroy narcotics and QMA 7 indicated she wasted the			

	Fentanyl patch by herself, without an explanation as to why she did not have a witness to destroy the patch with her. QMA 7 was placed on the agency DNR (Do Not Return to the facility) list due to the suspicion of drug diversion. 5. An undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated on 5/23/21 at 9:45 a.m., LPN 8 (an agency nurse) gave Resident F another resident's medication. LPN 8 was educated and the agency company was notified of the medication error. The following listed medications were the medications LPN 8 administered to Resident F instead of her routinely scheduled medications for her morning doses on 5/23/21. Norco 5/325 mg. Plavix (medication used to prevent plaque from building up a resident's arteries) 75 mg. Eliquis (a medication used to thin the blood to prevent blood clots) 5 mg. Motorola 50 mg used for high blood pressure.			

	Ranolazene ER (Extended Release) (a medication used to treat heart disease) 500 mg. Buspirone (a medication used to treat anxiety disorders) 7.5 mg. Lyrica (a non-narcotic medication used to treat nerve pain) 150 mg. Resident F's record was reviewed on 7/12/21 at 4:58 p.m. The diagnoses included, but were not limited to, MS (Multiple Sclerosis), epilepsy, type 2 diabetes mellitus and depression. A progress note, dated 5/23/21 at 4:24 p.m., indicated Resident F was given the wrong medication. The physician was notified and the resident's BP was monitored. Her initial BP was 133/78 with the most recent BP of 103/72. During an interview, on 7/12/21 at 2:00 p.m., the DON indicated LPN 8 gave Resident F another resident's medications, who lived in close proximity to her. She indicated LPN 8 did not admit to pre-setting up her medications for the medication administration pass, but it was the only explanation she could think about to explain how this resident got another resident's medication. A current policy, titled "Medication Administration			

	Program Policy" dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...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. b. Subscriber's orders for discontinued			

	medications are maintained. c. Medication 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. 6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...." A current policy, titled "Medication Disposal Policy," with a revision date of 8/11/18, indicated "Policy: Discontinued medications must be removed from the medication cart and disposed of according to state and federal regulations and following procedures established by community consulting pharmacy. Procedures: Disposal of outdated, discontinued, recalled medications shall occur no longer than seven days after the discontinuation. Disposal of all controlled medications is accomplished by one of the following methods: pouring into a dissolving medication solution, coffee grounds, kitty litter or destruction by cutting in small pieces and placing in the drug buster and witnessed by the Executive Director/Director of Health and Wellness or another facility employee approved by the Executive Director/Direct tor of Health and Wellness to perform this function. For all types of medications, a Drug			

	Disposal Record must be completed which includes the following information: 1. Name of medication 2. Remaining amount of medication being disposed 3. Resident name 4. Reason of disposal 5. Method of disposal 6. Date of Disposal 7. Signature of the two witnesses disposing of the medication. Controlled medications require additional documentation when disposal takes place. A Narcotic Count Sheet (in addition to the Drug Disposal record) is also signed by the two witnesses, verifying the number of medications being disposed, date and why medication is discontinued. Disposal of non-controlled medications may be performed by two Qualified Medication Aides. This Residential tag relates to Complaints IN00357191 and IN00357605. Based on interview and record review, the facility failed to ensure residents' medications were administered as ordered by the physician, related to medications were given to the wrong resident, omitted medications, a narcotic patch was removed prior to the due date and extra medication doses were given for 5 of 10 residents reviewed for medication administration			

	(Residents B, C, D, E and F). This deficit practice resulted in a QMA (Qualified Medication Aide) 4 committing a medication error which resulted in Resident B having an adverse reaction of hypotension (low blood pressure), an altered mental status (a change in the resident's mental condition) and she was admitted to an ICU (Intensive Care Unit) at a hospital to monitor her blood pressure overnight. Findings include: 1. A document, titled "Indiana State Department of Health Survey Report System," dated 7/1/21, was provided by the DON (Director of Nursing) on 7/9/21 at 5:00 p.m. This document indicated QMA 4 committed a medication error on 6/30/21 at 8:01 p.m., while administering Resident B's evening medications to her and the resident was admitted to a hospital ICU overnight for monitoring of her low BP (blood pressure) and mental status change. Resident B's record was reviewed on 7/12/21 at 12:45 p.m. The diagnoses included, but were not limited to, paranoid schizophrenia, major depressive disorder, diabetes mellitus, bipolar disorder and anxiety disorder.			

	The progress notes included, but were not limited to, the following: On 6/30/21 at 8:50 p.m., the note indicated a QMA gave a medication error to Resident B, then the QMA notified the DON, who overseen the assessment. Resident B's BP was 104/68 at the time of the occurrence of the medication error. The resident's new BP was 86/60 at the time when the physician was notified of the medication error and the resident was sent to the ER for evaluation and treatment. On 7/1/21 at 7:22 a.m., the note indicated the DON received a phone call from a QMA at 7:30 p.m., indicating she had given Resident B the wrong medication. The DON had the QMA list all the medications the resident received in error. BP at that time was 104/78. On 7/1/21 at 7:23 a.m., the note indicated the DON received a phone call from the QMA. The resident's BP continued to drop at that time, the QMA was instructed to call 911 and the resident was sent to the ER. On 7/1/21 at 9:28 a.m., the note indicated Resident B remained at the hospital. A document, titled "Medication Error Report," dated 7/1/21, indicated a medication error was committed on 6/30/21 at 7:30			

p.m., by a QMA. The QMA administered the wrong medication to Resident B and omitted this resident's regularly scheduled medication. The resident was sent to the ER (Emergency Room) for evaluation and treatment due to her BP was dropping, then she was admitted to the hospital to the ICU (Intensive Care Unit) for monitoring overnight. This QMA was suspended while an investigation was completed. The following listed medications were the medications QMA 4 administered to Resident B instead of her routinely scheduled medications for evening and bedtime on 6/30/21.

Atorvastatin (a medication used to treat high cholesterol) 80 mg.

Apixabar (a medication used to thin the blood to treat blood clots) 5 mg.

Norco (a narcotic medication used to treat pain) 5/325 mg.

Motorola (a medication used to treat high blood pressure and heart disease) 25 mg.

Tizanidine (a medication used to treat muscle cramps) 2 mg.

A document, dated 7/1/21 at 2:00 p.m., was provided by the DON on 7/9/21 at 5:00 p.m. The ED (Executive Director) signed her name to this document

	indicating this was the statement from QMA (Qualified Medication Aide) 4, who indicated in this statement she had pre-set three resident's medications and Resident B was the resident who was given the wrong medication. QMA 4 indicated in this statement, she pre-set three residents' medications, then she went to administer those medications. When she went to administer Resident B and her husband's medications to them, she gave Resident B the medications for the resident who lived across the hallway from her. QMA 4 realized she gave Resident B the wrong medication when she walked out of her apartment and looked down at the pill cup in her hand. A document, untitled, dated 7/2/21, was provided by the DON on 7/9/21 at 5:00 p.m. The document indicated QMA 4 met with the ED and DON regarding the investigation of the medication error for Resident B. During the interview, QMA 4 indicated she had pre-set medications for three residents, which resulted in a medication error with an adverse reaction, resulting in a hospitalization for Resident B. QMA 4 was terminated based on the "harmful medication error, resulting in hospitalization." During an interview, on 7/9/21 at			

	3:34 p.m., the DON indicated QMA 4 wrote a statement indicating she "caused" the medication error on 6/30/21 with Resident B. She had pre-set three different residents' medications and she gave Resident B the medications for the resident who lived across the hallway from her. QMA 4 was suspended during the investigation of the medication error, then she was terminated once the ED and DON received her written statement indicating she had pre-set her medications. The DON indicated prior to starting her shift on 6/30/21, QMA 4 attended an in-service related to pre-setting medications and causing injury to residents when staff pre-set medications. A document, titled "Medication Administration Inservice," dated 6/30/21, was provided by the DON on 7/9/21 at 5:00 p.m. The in-service document was signed by QMA 4 indicating she was at the in-service. The material discussed during the in-service included, but was not limited to, the following information: Six rights to medication administration, always do three checks with medication administration and never preset medications. 2. Resident C's record was reviewed on 7/12/21 at 1:07 p.m. The diagnoses included,			

	but were not limited to, Parkinson's Disease, Bipolar Disorder, unspecified convulsions and anxiety disorder. A document, titled "Level of Service Assessment/Evaluation-Full List of Items-Assisted Living," dated 6/24/21 indicated her medication service plan indicated she did not know the name, reason or time of her medications, and she would receive medications, insulin and glucometer checks from staff and be supported to take all medications safely and as ordered. The Electronic Medication Administration Record (EMAR), dated June 2021, included, but was not limited to, the following physician's order: Clonazepam (a medication used to treat anxiety) 0.5 mg give one tablet two times a day for anxiety-scheduled to be given at 9:00 a.m. and 5:00 p.m. (On 6/29/21 both times were initialed indicating the resident received this medication at the scheduled times. A document, titled "Controlled Drug Use Record," dated 6/27/21 through 7/5/21, indicated on 6/29/21, Resident C received his Clonazepam 0.5 mg on the following times 8:00			

	a.m., 5:00 p.m. and 8:23 p.m. The progress notes and physician's orders were reviewed and no documentation was found to indicate Resident C should have received an extra dose of Clonazepam on 6/29/21 at 8:23 p.m. During an interview, on 7/12/21 at 2:00 p.m., when the DON was asked about three doses of Clonazepam 0.5 mg being given on 6/29/21 instead of two doses being given, she indicated she would have to ask if there was an extra dose given or not. During an interview, on 7/12/21 at 3:50 p.m., the DON indicated there was not an order for Resident C to have an extra Clonazepam on 6/29/21 at 8:30 p.m., so the dose was a medication error. The medication administration times for the medication should have been 9:00 a.m. and 5:00 p.m. 3. An undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated Resident D received the wrong dosage of Clonazepam on 5/31/21 at 8:20 p.m. The wrong resident's medication card with the wrong dosage was pulled and Resident D received 0.5 mg of Clonazepam instead of 0.25 mg. No adverse reaction occurred			

	from this medication error. The staff member was given education on slowing down and doing the six medication rights when administering medication to residents. Resident D's record was reviewed on 7/12/21 at 3:38 p.m. The diagnoses included, but were not limited to, superjacent tachycardia, alcohol abuse and aphasia following a cerebral infarction. The Electronic Medication Administration Record (EMAR), dated May 2021, included, but was not limited to, the following order: Clonazepam Tablet 0.5 mg, give 0.25 mg (1/2 tablet of a 0.5 mg tablet) by mouth two times a day related to anxiety disorder-scheduled for 7:00 a.m. and 7:00 p.m. A document, titled "Controlled Drug Use Record," dated 5/10/21 through 6/5/21, had documentation which indicated on 5/17/21, Resident D received a Clonazepam 0.25 mg dose at 8:00 a.m., 7:00 p.m. and 7:20 p.m.			

	The progress notes and physician's orders were reviewed and no documentation was found to indicate Resident D should have received the extra dose of Clonazepam on 5/17/21 at 7:20 p.m. A progress note, dated 5/31/21 at 10:22 p.m., indicated Resident D had an order for Clonazepam 0.5 mg tablet for anxiety disorder, he was supposed to be administered 0.25 mg by mouth two times per day. The order was written as to give 1/2 tablet of a 0.5 mg Clonazepam tablet twice daily. The resident's medication was in the narcotic box with another resident's medications and the QMA administering his medications pulled a card and read the label too quickly. When she read the label of Resident L's Clonazepam card of 0.5 mg she pushed the pill out into a medicine cup and administered it to Resident D at approximately 6:30 p.m. Then around 8:00 p.m., when the QMA was ready to count the narcotic box for the cart, she realized Resident L had a Clonazepam Disintegrated tablet 0.5 mg missing. This was when, she realized she administered the missing Clonazepam disintegrated 0.5 mg tablet to Resident D and she had made a medication error. The resident was monitored and no adverse reactions occurred			

	from this medication error. During an interview, on 7/12/21 at 2:00 p.m., the DON indicated QMA 6 pulled Resident L's Clonazepam 0.5 mg card from the narcotic box and punched out one pill instead of pulling Resident D's card from the narcotic box. The narcotic cards in the narcotic box were not alphabetized and Resident L's Clonazepam card was right in front of Resident D's Clonazepam card and since both residents names were similar, Resident L's Clonazepam card was used instead of Resident D's card. During an interview, on 7/12/21 at 4:35 p.m., the DON was asked about Resident D receiving an extra dose of Clonazepam on 5/17/21 at 7:20 p.m., she indicated she did not know why he received an extra dose of Clonazepam that day because he should have only received it twice as ordered. His second dose for the day was scheduled for 7:00 p.m., which was at the change of shift, so the day shift person may have administered it and forgotten to document the medication as given in the EMAR, but signed it out on the narcotic sheet. Since the day shift staff member might not have documented it in the EMAR as given then it would stay "popped up" (lit up on the computer screen to indicate it			

	was time for the medication to be administered) for the next staff member and this may have been why she gave the extra dose, which would make three doses given in a 24 hour period a medication error. 4. A undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated on 4/22/21 on the dayshift, Resident E's Fentanyl patch (a narcotic medication used to control high levels of pain) 25 mcg (micrograms) was removed by QMA 7 and a new patch was placed. The administration of a new Fentanyl patch was a medication error related to QMA 7 placed the new patch on Resident E on the wrong date and shift. The resident's physician wrote a new order for an extra patch, the facility covered the cost of the patch and the new patch was applied on 4/23/21, on the evening shift as ordered. The facility nurses and QMAs were in-serviced on 4/28/21, over the six rights of administering medication. The agency company QMA 7 worked for was notified and she was placed on a "Do Not Return to the Facility" list and she would not be allowed back into the facility to care for residents. Resident E's record was reviewed on 7/12/21 at 4:45			

p.m. The diagnoses included, but were not limited to, chronic pain, mild cognitive impairment, hypotension and major depressive disorder.

The Electronic Medication Administration Record (EMAR), dated April 2021, included, but was not limited to, the following order:

Fentanyl Patch 72 hour 25 mcg/hr apply one patch transdermally (apply to the skin) every 72 hours for pain and remove according to the ordered schedule every 72 hours. The patch was scheduled to be removed at 5:29 p.m., and a new patch applied at 5:30 p.m.

Resident E's EMAR for this medication indicated it was changed on 4/20/21 at 6:00 p.m., then changed on 4/23/21 at 5:29 p.m.

A progress note, dated 4/23/21 at 3:47 p.m., indicated a medication error was discovered with Resident E's Fentanyl Patch administration on 4/22/21. An order for one extra Fentanyl patch was written by the Physician, which will be taken from the EDK (Emergency Drug Kit), then the facility will pay for the extra patch.

The progress notes and EMAR were reviewed and no documentation was found,

	which indicated QMA 7 documented Resident E's Fentanyl patch change or the destruction of the patch she removed from 4/22/21. A document, titled "Pharmacy Communication Memo," dated 4/28/21, from the facility pharmacy indicated Resident E's Fentanyl Patch 25 mcg/hr (hour) was ordered too soon. The date of the last fill was 4/5/21 and the next fill will be sent on 4/29/21. The "Notes" section indicated this item was not covered by the resident's insurance until 4/29/21, due to it was filled at another pharmacy on 4/5/21. The facility's action to be taken indicated there was a medication error committed and the resident was one patch short and the facility would guarantee payment for the Fentanyl patch being ordered on 4/28/21. During an interview, on 7/12/21 at 2:00 p.m., the DON indicated on 4/22/21, QMA 7 changed a newly applied Fentanyl patch (the patch was applied the day prior) on Resident E. When asked why she applied a new patch prior to the date ordered, QMA 7 indicated she read the date on the EMAR wrong. The DON indicated she committed a medication error because she did not follow the policy and procedures for administering the medication and she did not			

dispose of the used Fentanyl patch according to their policy either. There were supposed to be two nurses or one nurse and a QMA destroy narcotics and QMA 7 indicated she wasted the Fentanyl patch by herself, without an explanation as to why she did not have a witness to destroy the patch with her. QMA 7 was placed on the agency DNR (Do Not Return to the facility) list due to the suspicion of drug diversion.

5. An undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated on 5/23/21 at 9:45 a.m., LPN 8 (an agency nurse) gave Resident F another resident's medication. LPN 8 was educated and the agency company was notified of the medication error.

The following listed medications were the medications LPN 8 administered to Resident F instead of her routinely scheduled medications for her morning doses on 5/23/21.

Norco 5/325 mg.

Plavix (medication used to prevent plaque from building up a resident's arteries) 75 mg.

Eliquis (a medication used to thin the blood to prevent blood clots) 5 mg.

	Motorola 50 mg used for high blood pressure. Ranolazene ER (Extended Release) (a medication used to treat heart disease) 500 mg. Buspirone (a medication used to treat anxiety disorders) 7.5 mg. Lyrica (a non-narcotic medication used to treat nerve pain) 150 mg. Resident F's record was reviewed on 7/12/21 at 4:58 p.m. The diagnoses included, but were not limited to, MS (Multiple Sclerosis), epilepsy, type 2 diabetes mellitus and depression. A progress note, dated 5/23/21 at 4:24 p.m., indicated Resident F was given the wrong medication. The physician was notified and the resident's BP was monitored. Her initial BP was 133/78 with the most recent BP of 103/72.			

	During an interview, on 7/12/21 at 2:00 p.m., the DON indicated LPN 8 gave Resident F another resident's medications, who lived in close proximity to her. She indicated LPN 8 did not admit to pre-setting up her medications for the medication administration pass, but it was the only explanation she could think about to explain how this resident got another resident's medication. A current policy, titled "Medication Administration Program Policy" dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...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. b. Subscriber's orders for discontinued medications are maintained. c. Medication 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. 6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...." A current policy, titled "Medication Disposal Policy," with a revision date of 8/11/18, indicated "Policy: Discontinued medications must be removed from the medication cart and disposed of according to state and federal regulations and following procedures established by community consulting pharmacy. Procedures: Disposal of outdated, discontinued, recalled medications shall occur no longer than seven days after the			

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	Complaints IN00357191 and IN00357605.			
R 0244	Health Services - Noncompliance 410 IAC 16.2-5-4(e)(4) (4) Preparation of doses for more than one (1) scheduled administration is not permitted. Based on interview and record review, the facility failed to ensure medications were not prepared and administered for more than one scheduled administration for 1 of 10 residents being observed for medication administration pass (Resident B). Finding includes: 1. A document, titled "Indiana State Department of Health Survey Report System," dated 7/1/21, was provided by the DON (Director of Nursing) on 7/9/21 at 5:00 p.m. This document indicated QMA 4 committed a medication error on 6/30/21 at 8:01 p.m., while administering Resident B's evening medications to her and the resident was admitted to a hospital ICU overnight for monitoring of her low BP (blood pressure) and mental status change. Resident B's record was reviewed on 7/12/21 at 12:45	R 0244	**Tag; Title; Deficiency or Offense:** **R 244** **Health Services – Noncompliance** **Preparation of doses for more than one (1) scheduled administration is not permitted.** **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 that medication administration is not prepared or administered for more than one resident at a time, in accordance with physician order and in	08/30/2021

	p.m. The diagnoses included, but were not limited to, paranoid schizophrenia, major depressive disorder, diabetes mellitus, bipolar disorder and anxiety disorder. The progress notes included, but were not limited to, the following: On 6/30/21 at 8:50 p.m., the note indicated a QMA gave a medication error to Resident B, then the QMA notified the DON, who overseen the assessment. Resident B's BP was 104/68 at the time of the medication error. The resident's BP was 86/60 at the time when the physician was notified of the medication error and the resident was sent to the ER for evaluation and treatment. On 6/30/21 at 10:34 p.m., the note indicated the resident's routine medications were withheld by the nurse. On 7/1/21 at 7:22 a.m., the note indicated the DON received a phone call from a QMA at 7:30 p.m., indicating she had given Resident B the wrong medication. The DON had the QMA list all the medications the resident received in error. BP at that time was 104/78. On 7/1/21 at 7:23 a.m., the note indicated the DON received a phone call from the QMA. The resident's BP continued to drop, the QMA was instructed to call		compliance with company policy and procedures and applicable federal, state and local laws. **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;** Residents of the community receiving medication services have the potential to be affected by the alleged Noncompliance. Executive Director or Designee to conduct nursing staff In-Service on the “5 Rights of Medication Administration on or before 08/30/2021. **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 place a	

	911 and the resident was sent to the ER. On 7/1/21 at 9:28 a.m., the note indicated Resident B remained at the hospital. A document, titled "Medication Error Report," dated 7/1/21, indicated a medication error was committed on 6/30/21 at 7:30 p.m., by a QMA. The QMA administered the wrong medication to Resident B and omitted this resident's regularly scheduled medication. The resident was sent to the ER (Emergency Room) for evaluation and treatment due to her BP was dropping, then she was admitted to the hospital to the ICU (Intensive Care Unit) for monitoring overnight. The QMA was suspended while an investigation was completed. The following listed medications were the medications QMA 4 administered to Resident B instead of her routinely scheduled medications for evening and bedtime on 6/30/21. Atorvastatin (a medication used to treat high cholesterol) 80 mg. Apixabar (a medication used to thin the blood to treat blood clots) 5 mg. Norco (a narcotic medication used to treat pain) 5/325 mg. Motorola (a medication used to		nursing education information card on each medication cart outlining the “5 RIGHT OF MEDICATION ADMINISTRATION”. **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;** A CQI monitoring tool will be implemented on 08/16/21 to ensure compliance; the Executive Director or Designee will monitor daily for 2 weeks; weekly for 4 weeks; then monthly until compliance is maintained consecutively for 3 months or until the Quality Assurance Committee finds compliance has been met and/or makes further recommendations are made. **What date the systemic changes will be completed: 08/16/2021**	

	treat high blood pressure and heart disease) 25 mg. Tizanidine (a medication used to treat muscle cramps) 2 mg. A document, dated 7/1/21 at 2:00 p.m., was provided by the DON on 7/9/21 at 5:00 p.m. The ED (Executive Director) signed her name to this document indicating this was the statement from QMA (Qualified Medication Aide) 4, who indicated she had pre-set three resident's medications. Resident B was the resident who was given the wrong medication. QMA 4 indicated she pre-set three residents' medications, then she went to administer those medications. When she went to administer Resident B and her husband's medications to them, she gave Resident B the medications set-up for the resident who lived across the hallway from her. QMA 4 realized she gave Resident B the wrong medication when she walked out of her apartment and looked down at the pill cup in her hand. She realized she had given the wrong medication to Resident B. An untitled document, dated 7/2/21, was provided by the DON on 7/9/21 at 5:00 p.m. The document indicated QMA 4 met with the ED and DON regarding the investigation of the medication error for Resident B.		We respectfully request paper compliance for the alleged Noncompliance.	

	During the interview, QMA 4 indicated she had pre-set medications for three residents, which resulted in a medication error and in a hospitalization for Resident B. QMA 4 was terminated based on the "harmful medication error, resulting in hospitalization." During an interview, on 7/9/21 at 3:34 p.m., the DON indicated QMA 4 wrote a statement indicating she "caused" the medication error on 6/30/21 with Resident B. She had pre-set up three different residents' medications and she gave Resident B the resident's medications who lived across the hallway from her. QMA 4 was suspended during the investigation of the medication error, then she was terminated once the ED and DON received her written statement indicating she had pre-set her medications. The DON indicated prior to starting her shift on 6/30/21, QMA 4 attended an in-service related to pre-setting medications and causing injury to residents when staff pre-set medications. A document, titled "Medication Administration Inservice," dated 6/30/21, was provided by the DON on 7/9/21 at 5:00 p.m. The in-service document was signed by QMA 4 indicating she was at the in-service. The material discussed during the in-service			

	included, but was not limited to, the following information: Six rights to medication administration, always do three checks with medication administration and never preset medications. A current policy, titled "Medication Administration Program Policy," dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...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. b. Subscriber's orders for discontinued medications are maintained. c. Medication 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. 6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...." This Residential tag relates to Complaints IN00357191 and IN00357605. Based on interview and record review, the facility failed to ensure medications were not prepared and administered for more than one scheduled administration for 1 of 10 residents being observed for medication administration pass (Resident B). Finding includes: 1. A document, titled "Indiana State Department of Health Survey Report System," dated 7/1/21, was provided by the DON (Director of Nursing) on			

7/9/21 at 5:00 p.m. This document indicated QMA 4 committed a medication error on 6/30/21 at 8:01 p.m., while administering Resident B's evening medications to her and the resident was admitted to a hospital ICU overnight for monitoring of her low BP (blood pressure) and mental status change.

Resident B's record was reviewed on 7/12/21 at 12:45 p.m. The diagnoses included, but were not limited to, paranoid schizophrenia, major depressive disorder, diabetes mellitus, bipolar disorder and anxiety disorder.

The progress notes included, but were not limited to, the following:

On 6/30/21 at 8:50 p.m., the note indicated a QMA gave a medication error to Resident B, then the QMA notified the DON, who overseen the assessment. Resident B's BP was 104/68 at the time of the medication error. The resident's BP was 86/60 at the time when the physician was notified of the medication error and the resident was sent to the ER for evaluation and treatment.

On 6/30/21 at 10:34 p.m., the note indicated the resident's routine medications were withheld by the nurse.

On 7/1/21 at 7:22 a.m., the note

	indicated the DON received a phone call from a QMA at 7:30 p.m., indicating she had given Resident B the wrong medication. The DON had the QMA list all the medications the resident received in error. BP at that time was 104/78. On 7/1/21 at 7:23 a.m., the note indicated the DON received a phone call from the QMA. The resident's BP continued to drop, the QMA was instructed to call 911 and the resident was sent to the ER. On 7/1/21 at 9:28 a.m., the note indicated Resident B remained at the hospital. A document, titled "Medication Error Report," dated 7/1/21, indicated a medication error was committed on 6/30/21 at 7:30 p.m., by a QMA. The QMA administered the wrong medication to Resident B and omitted this resident's regularly scheduled medication. The resident was sent to the ER (Emergency Room) for evaluation and treatment due to her BP was dropping, then she was admitted to the hospital to the ICU (Intensive Care Unit) for monitoring overnight. The QMA was suspended while an investigation was completed. The following listed medications were the medications QMA 4 administered to Resident B instead of her routinely			

scheduled medications for evening and bedtime on 6/30/21.

Atorvastatin (a medication used to treat high cholesterol) 80 mg.

Apixabar (a medication used to thin the blood to treat blood clots) 5 mg.

Norco (a narcotic medication used to treat pain) 5/325 mg.

Motorola (a medication used to treat high blood pressure and heart disease) 25 mg.

Tizanidine (a medication used to treat muscle cramps) 2 mg.

A document, dated 7/1/21 at 2:00 p.m., was provided by the DON on 7/9/21 at 5:00 p.m. The ED (Executive Director) signed her name to this document indicating this was the statement from QMA (Qualified Medication Aide) 4, who indicated she had pre-set three resident's medications. Resident B was the resident who was given the wrong medication. QMA 4 indicated she pre-set three residents' medications, then she went to administer those medications. When she went to administer Resident B and her husband's medications to them, she gave Resident B the medications set-up for the resident who lived across the hallway from her. QMA 4 realized she gave Resident B

	the wrong medication when she walked out of her apartment and looked down at the pill cup in her hand. She realized she had given the wrong medication to Resident B. An untitled document, dated 7/2/21, was provided by the DON on 7/9/21 at 5:00 p.m. The document indicated QMA 4 met with the ED and DON regarding the investigation of the medication error for Resident B. During the interview, QMA 4 indicated she had pre-set medications for three residents, which resulted in a medication error and in a hospitalization for Resident B. QMA 4 was terminated based on the "harmful medication error, resulting in hospitalization." During an interview, on 7/9/21 at 3:34 p.m., the DON indicated QMA 4 wrote a statement indicating she "caused" the medication error on 6/30/21 with Resident B. She had pre-set up three different residents' medications and she gave Resident B the resident's medications who lived across the hallway from her. QMA 4 was suspended during the investigation of the medication error, then she was terminated once the ED and DON received her written statement indicating she had pre-set her medications. The DON indicated prior to starting her shift on			

	6/30/21, QMA 4 attended an in-service related to pre-setting medications and causing injury to residents when staff pre-set medications. A document, titled "Medication Administration Inservice," dated 6/30/21, was provided by the DON on 7/9/21 at 5:00 p.m. The in-service document was signed by QMA 4 indicating she was at the in-service. The material discussed during the in-service included, but was not limited to, the following information: Six rights to medication administration, always do three checks with medication administration and never preset medications. A current policy, titled "Medication Administration Program Policy," dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents			

	receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...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. b. Subscriber's orders for discontinued medications are maintained. c. Medication 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. 6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...." This Residential tag relates to Complaints IN00357191 and IN00357605.			

R 0306	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(g)(1-9) (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure the facility's policies and procedures were followed when controlled substance medications were to be destroyed related to discontinued medications and a medication error for 2 of 5 residents reviewed for proper	R 0306	**Tag; Title; Deficiency or Offense:** **R 306 Pharmaceutical Services-Noncompliance** **Medications administered by the facility shall be disposed in compliance with appropriate federal, state and local laws, and deposition of any released, returned, or destroyed medication shall be documented in the residents' clinical record and shall include the following information : 1) Name of resident, 2) Name & Strength of the drug; 3) Prescription Number; 4) Reason for disposal; 5) The amount disposed; 6) The method of disposal; 7) The date of disposal; 8) The signature of the person conducting the disposal of the drug; 9) The signature of the witness, if any, to the disposal of the drug.** **What corrective action will be accomplished for those residents found to have been affected by the**	08/30/2021

disposition of controlled substances (Resident C and E).

Findings include:

1. Resident C's record was reviewed on 7/12/21 at 1:07 p.m. The diagnoses included, but were not limited to, Parkinson's Disease, Bipolar Disorder, unspecified convulsions and anxiety disorder.

While reviewing this resident's record, the top part of a drug card was located which had been torn off the Clonazepam card and D/C (discontinued) was handwritten on the card.

A document, titled "Level of Service Assessment/Evaluation-Full List of Items-Assisted Living," dated 6/24/21 indicated her medication service plan indicated she did not know the name, reason or time of her medications, and she would receive medications, insulin and glucometer checks from staff and be supported to take all medications safely and as ordered.

The Electronic Medication Administration Record (EMAR), dated June 2021, included, but was not limited to, the following physician's order, which were not administered to the resident as ordered:

deficient practice;

The Executive Director or Designee to ensure that destruction of medications are disposed of and documented in accordance with company policy and procedure and federal, state and local laws.

How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

All residents have the potential to be affected by the alleged Offense.

Executive Director or Designee to conduct nursing staff In-Service on the Destruction of Medication Administration on or before 08/30/2021.

What measures will be put

	Clonazepam (a medication used to treat anxiety) 0.5 mg give one tablet two times a day for anxiety-scheduled to be given at 9:00 a.m. and 5:00 p.m. (On 6/29/21 both times were initialed indicating the resident received this medication at the scheduled times). A document, titled "Controlled Drug Use Record," dated 6/27/21 through 7/5/21, indicated on 6/29/21, Resident C received his Clonazepam 0.5 mg on 6/29/21 at the following times 8:00 a.m., 5:00 p.m. and 8:23 p.m. The progress notes and physician's orders were reviewed and no documentation was found to indicate Resident C should have received an extra dose of Clonazepam on 6/29/21 at 8:23 p.m. During an interview, on 7/12/21 at 2:00 p.m., when asked about the top of the Clonazepam narcotic card being in Resident C's chart and where did the pills go, since the narcotic sheet indicated there should be 43 pills left, the DON indicated she did not know why the card was in the chart, nor did she know what happened to the 43 pills because when the medications were destroyed the destruction information was to be written on the narcotic count sheet by two nurses or a nurse and a QMA.		**into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** The Executive Director or the Designee to monitor destruction of medication assuring company policy and procedure are followed and in compliance with federal, state and local laws. **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;** A CQI monitoring tool will be implemented on 08/16/21 to ensure compliance; the Executive Director or Designee will monitor daily for 2 weeks; weekly for 4 weeks; then monthly until compliance is maintained consecutively for 3 months or until the Quality Assurance Committee finds compliance has been met and/or makes further recommendations are made.	

	Then the narcotic sheet was filed into the residents' record. When the DON was asked about three doses of Clonazepam 0.5 mg being given on 6/29/21 instead of two doses being given, she indicated she would have to ask if there was an extra dose given or not. She indicated she knew the resident was taken off the Clonazepam and switched to Valium (a medication used to treat anxiety), but she was unsure of the date the order was written, but she would find out the answers to these questions. During an interview, on 7/12/21 at 3:30 p.m., LPN 5, QMA 3 and the DON were in attendance. LPN 5 indicated the resident received a new order for Valium on 7/5/21, so she and QMA 3 wasted the 43 tablets of Clonazepam, but they did not sign off on the Clonazepam sheet to indicate the pills had been destroyed. She indicated QMA 3 paper clipped the top of the card with "D/C" written on it to the narcotic sheet to remind them to sign the sheet and someone, must have filed it in his record prior to them documenting they had destroyed the medication. During an interview, on 7/12/21 at 3:50 p.m., the DON indicated there was no order for Resident C to have an extra Clonazepam on 6/29/21 at 8:30 p.m., so the		**<u>What date the systemic changes will be completed:</u>** **08/16/2021** We would like to request paper compliance for all Noncompliance.	

	dose was a medication error. The medication administration times for the medication should have been 9:00 a.m. and 5:00 p.m. The last date his Clonazepam was administered was on 7/5/21 at 8:00 a.m., then QMA 3 and LPN 5 destroyed the remaining 43 pills, but they forgot to sign the narcotic sheet.			

2. An undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated on 4/22/21 on the dayshift, Resident E's Fentanyl patch (a narcotic medication used to control high levels of pain) 25 mcg (micrograms) was removed by QMA 7 and a new patch was placed on the resident. The administration of a new Fentanyl patch was a medication error related to QMA 7 placed the new patch on Resident E on the wrong date and shift. The resident's physician wrote a new order for an extra patch, the facility covered the cost of the patch and the new patch was applied on 4/23/21 on the evening shift as ordered. The facility nurses and QMAs were in-serviced on 4/28/21, over the six rights of administering medication. The agency company QMA 7 worked for was notified and she was placed on a "Do Not Return" list and she will not be allowed back into the facility to care for residents.

Resident E's record was reviewed on 7/12/21 at 4:45 p.m. The diagnoses included, but were not limited to, chronic pain, mild cognitive impairment, hypotension and major depressive disorder.

The Electronic Medication Administration Record (EMAR),

dated April 2021, included, but was not limited to, the following order:

Fentanyl Patch 72 hour 25 mcg/hr apply one patch transdermally (apply to the skin) every 72 hours for pain and remove according to the schedule every 72 hours. The patch was scheduled to be removed at 5:29 p.m., and a new patch applied at 5:30 p.m. (Resident E's EMAR for this medication noted it was changed on 4/20/21 at 6:00 p.m., then changed on 4/23/21 at 5:29 p.m.)

A progress note, dated 4/23/21 at 3:47 p.m., indicated a medication error was discovered with Resident E's Fentanyl Patch administration on 4/22/21. An order for one extra Fentanyl patch was written by the physician, which would be taken from the EDK (Emergency Drug Kit) and the facility will pay for the extra patch.

The progress notes and EMAR were reviewed and no documentation was found to indicate QMA 7 documented Resident E's Fentanyl patch change or the destruction of the patch she removed from 4/22/21.

A document, titled "Pharmacy Communication Memo," dated 4/28/21, from the facility

pharmacy indicated Resident E's Fentanyl Patch 25 mcg/hr (hour) was ordered too soon. The date of the last fill was 4/5/21 and the next fill will be sent on 4/29/21. The "Notes" section indicated this item was not covered by the resident's insurance until 4/29/21, due to it was filled at another pharmacy on 4/5/21. The facility's action to be taken indicated there was a medication error committed and the resident was one patch short and the facility would guarantee payment for the Fentanyl patch being ordered on 4/28/21.

During an interview, on 7/12/21 at 2:00 p.m., the DON indicated on 4/22/21, QMA 7 changed a newly applied Fentanyl patch (the patch was applied the day prior) on Resident E. When asked why she applied a new patch prior to the date ordered, QMA 7 indicated she read the date on the EMAR wrong. The DON indicated she committed a medication error because she did not follow the policy and procedures for administering the medication and she did not dispose of the used Fentanyl patch according to their policy either. There was supposed to be two nurses or one nurse and a QMA present to destroy narcotics. QMA 7 indicated she wasted the Fentanyl patch by herself, without an explanation as to why she did not have a

witness to destroy the patch. QMA 7 was placed on the agency DNR list due to suspicion of diversion of drugs.

A current policy, titled "Medication Administration Program Policy," dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program...5. Documentation in the medication record is complete and accurate. a. Resident receives medications as prescribed. b. Subscriber's orders for discontinued medications are maintained. c.

Medication record is correctly noted, with signatures and explanations for missed medications noted properly...6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...."

A current policy, titled "Medication Disposal Policy," with a revision date of 8/11/18, indicated "Policy: Discontinued medications must be removed from the medication cart and disposed of according to state and federal regulations and following procedures established by community consulting pharmacy. Procedures: Disposal of outdated, discontinued, recalled medications shall occur no longer than seven days after the discontinuation. Disposal of all controlled medications is accomplished by one of the following methods: pouring into a dissolving medication solution, coffee grounds, kitty litter or destruction by cutting in small pieces and placing in the drug buster and witnessed by the Executive Director/Director of Health and Wellness or another facility employee approved by the Executive Director/Direct tor of Health and Wellness to perform this function. For all types of medications, a Drug Disposal Record must be completed which includes the following information: 1. Name

of medication 2. Remaining amount of medication being disposed 3. Resident name 4. Reason of disposal 5. Method of disposal 6. Date

of Disposal 7. Signature of the two witnesses disposing of the medication. Controlled medications require additional documentation when disposal takes place. A Narcotic Count Sheet (in addition to the Drug Disposal record) is also signed by the two witnesses, verifying the number of medications being disposed, date and why medication is discontinued. Disposal of non-controlled medications may be performed by two Qualified Medication Aides.

This Residential tag relates to Complaint IN00357605 and IN00357191.

Based on interview and record review, the facility failed to ensure the facility's policies and procedures were followed when controlled substance medications were to be destroyed related to discontinued medications and a medication error for 2 of 5 residents reviewed for proper disposition of controlled substances (Resident C and E).

Findings include:

1. Resident C's record was reviewed on 7/12/21 at 1:07

p.m. The diagnoses included, but were not limited to, Parkinson's Disease, Bipolar Disorder, unspecified convulsions and anxiety disorder.

While reviewing this resident's record, the top part of a drug card was located which had been torn off the Clonazepam card and D/C (discontinued) was handwritten on the card.

A document, titled "Level of Service Assessment/Evaluation-Full List of Items-Assisted Living," dated 6/24/21 indicated her medication service plan indicated she did not know the name, reason or time of her medications, and she would receive medications, insulin and glucometer checks from staff and be supported to take all medications safely and as ordered.

The Electronic Medication Administration Record (EMAR), dated June 2021, included, but was not limited to, the following physician's order, which were not administered to the resident as ordered:

Clonazepam (a medication used to treat anxiety) 0.5 mg give one tablet two times a day for anxiety-scheduled to be given at 9:00 a.m. and 5:00 p.m. (On 6/29/21 both times were initialed

indicating the resident received this medication at the scheduled times).

A document, titled "Controlled Drug Use Record," dated 6/27/21 through 7/5/21, indicated on 6/29/21, Resident C received his Clonazepam 0.5 mg on 6/29/21 at the following times 8:00 a.m., 5:00 p.m. and 8:23 p.m.

The progress notes and physician's orders were reviewed and no documentation was found to indicate Resident C should have received an extra dose of Clonazepam on 6/29/21 at 8:23 p.m.

During an interview, on 7/12/21 at 2:00 p.m., when asked about the top of the Clonazepam narcotic card being in Resident C's chart and where did the pills go, since the narcotic sheet indicated there should be 43 pills left, the DON indicated she did not know why the card was in the chart, nor did she know what happened to the 43 pills because when the medications were destroyed the destruction information was to be written on the narcotic count sheet by two nurses or a nurse and a QMA. Then the narcotic sheet was filed into the residents' record. When the DON was asked about three doses of Clonazepam 0.5 mg being given on 6/29/21 instead of two doses

being given, she indicated she would have to ask if there was an extra dose given or not. She indicated she knew the resident was taken off the Clonazepam and switched to Valium (a medication used to treat anxiety), but she was unsure of the date the order was written, but she would find out the answers to these questions.

During an interview, on 7/12/21 at 3:30 p.m., LPN 5, QMA 3 and the DON were in attendance. LPN 5 indicated the resident received a new order for Valium on 7/5/21, so she and QMA 3 wasted the 43 tablets of Clonazepam, but they did not sign off on the Clonazepam sheet to indicate the pills had been destroyed. She indicated QMA 3 paper clipped the top of the card with "D/C" written on it to the narcotic sheet to remind them to sign the sheet and someone, must have filed it in his record prior to them documenting they had destroyed the medication.

During an interview, on 7/12/21 at 3:50 p.m., the DON indicated there was no order for Resident C to have an extra Clonazepam on 6/29/21 at 8:30 p.m., so the dose was a medication error. The medication administration times for the medication should have been 9:00 a.m. and 5:00 p.m. The last date his Clonazepam was administered

was on 7/5/21 at 8:00 a.m., then QMA 3 and LPN 5 destroyed the remaining 43 pills, but they forgot to sign the narcotic sheet.

2. An undated document, titled "Medication Error Report," was provided by the DON on 7/9/21 at 4:45 p.m. This document indicated on 4/22/21 on the dayshift, Resident E's Fentanyl patch (a narcotic medication used to control high levels of pain) 25 mcg (micrograms) was removed by QMA 7 and a new patch was placed on the resident. The administration of a new Fentanyl patch was a medication error related to QMA 7 placed the new patch on Resident E on the wrong date and shift. The resident's physician wrote a new order for an extra patch, the facility covered the cost of the patch and the new patch was applied on 4/23/21 on the evening shift as ordered. The facility nurses and QMAs were in-serviced on 4/28/21, over the six rights of administering medication. The agency company QMA 7 worked for was notified and she was placed on a "Do Not Return" list and she will not be allowed back into the facility to care for residents.

Resident E's record was reviewed on 7/12/21 at 4:45 p.m. The diagnoses included, but were not limited to, chronic pain, mild cognitive impairment,

hypotension and major depressive disorder.

The Electronic Medication Administration Record (EMAR), dated April 2021, included, but was not limited to, the following order:

Fentanyl Patch 72 hour 25 mcg/hr apply one patch transdermally (apply to the skin) every 72 hours for pain and remove according to the schedule every 72 hours. The patch was scheduled to be removed at 5:29 p.m., and a new patch applied at 5:30 p.m. (Resident E's EMAR for this medication noted it was changed on 4/20/21 at 6:00 p.m., then changed on 4/23/21 at 5:29 p.m.)

A progress note, dated 4/23/21 at 3:47 p.m., indicated a medication error was discovered with Resident E's Fentanyl Patch administration on 4/22/21. An order for one extra Fentanyl patch was written by the physician, which would be taken from the EDK (Emergency Drug Kit) and the facility will pay for the extra patch.

The progress notes and EMAR were reviewed and no documentation was found to indicate QMA 7 documented Resident E's Fentanyl patch change or the destruction of the patch she removed from

4/22/21.

A document, titled "Pharmacy Communication Memo," dated 4/28/21, from the facility pharmacy indicated Resident E's Fentanyl Patch 25 mcg/hr (hour) was ordered too soon. The date of the last fill was 4/5/21 and the next fill will be sent on 4/29/21. The "Notes" section indicated this item was not covered by the resident's insurance until 4/29/21, due to it was filled at another pharmacy on 4/5/21. The facility's action to be taken indicated there was a medication error committed and the resident was one patch short and the facility would guarantee payment for the Fentanyl patch being ordered on 4/28/21.

During an interview, on 7/12/21 at 2:00 p.m., the DON indicated on 4/22/21, QMA 7 changed a newly applied Fentanyl patch (the patch was applied the day prior) on Resident E. When asked why she applied a new patch prior to the date ordered, QMA 7 indicated she read the date on the EMAR wrong. The DON indicated she committed a medication error because she did not follow the policy and procedures for administering the medication and she did not dispose of the used Fentanyl patch according to their policy either. There was supposed to be two nurses or one nurse and

a QMA present to destroy narcotics. QMA 7 indicated she wasted the Fentanyl patch by herself, without an explanation as to why she did not have a witness to destroy the patch. QMA 7 was placed on the agency DNR list due to suspicion of diversion of drugs.

A current policy, titled "Medication Administration Program Policy," dated 08/1/18, 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 state's administrative rules and regulations and orders from the physician. Procedure: 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 prescribe...3. Residents receiving medication assistance will have...b. Documentation of the medication name, dose, time taken by resident...The community Executive Director/Director of Health and Wellness will ensure adequate professional oversight of the medication treatment administration program...5. Documentation in the medication record is complete

and accurate. a. Resident receives medications as prescribed. b. Subscriber's orders for discontinued medications are maintained. c. Medication record is correctly noted, with signatures and explanations for missed medications noted properly...6. Narcotics, outdated and discontinued medications are accounted for and disposed of properly...."

A current policy, titled "Medication Disposal Policy," with a revision date of 8/11/18, indicated "Policy: Discontinued medications must be removed from the medication cart and disposed of according to state and federal regulations and following procedures established by community consulting pharmacy. Procedures: Disposal of outdated, discontinued, recalled medications shall occur no longer than seven days after the discontinuation. Disposal of all controlled medications is accomplished by one of the following methods: pouring into a dissolving medication solution, coffee grounds, kitty litter or destruction by cutting in small pieces and placing in the drug buster and witnessed by the Executive Director/Director of Health and Wellness or another facility employee approved by the Executive Director/Direct tor of Health and Wellness to

	perform this function. For all types of medications, a Drug Disposal Record must be completed which includes the following information: 1. Name of medication 2. Remaining amount of medication being disposed 3. Resident name 4. Reason of disposal 5. Method of disposal 6. Date of Disposal 7. Signature of the two witnesses disposing of the medication. Controlled medications require additional documentation when disposal takes place. A Narcotic Count Sheet (in addition to the Drug Disposal record) is also signed by the two witnesses, verifying the number of medications being disposed, date and why medication is discontinued. Disposal of non-controlled medications may be performed by two Qualified Medication Aides. This Residential tag relates to Complaint IN00357605 and IN00357191.				

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