

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER BELVEDERE SENIOR HOUSING		STREET ADDRESS, CITY, STATE, ZIP CODE 343 E 90TH DRIVE, MERRILLVILLE, , 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00383250. Complaint IN00383250 - Substantiated. State deficiency related to the allegations is cited at R0240. Unrelated deficiencies cited. Survey date: November 22, 2022 Facility number: 014178 Residential Census: 125 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/28/22.	R 0000	This Plan of Correction constitutes our written allegation of compliance for the deficiency cited, however, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the established state and federal law.		
R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the	R 0216	Belvedere Senior Housing	12/28/2022	

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evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, record review and interview, the facility failed to ensure a resident was evaluated for self-administration of medications, for 1 of 5 residents observed on a Medication Pass Administration who self-administered medication. (Resident D) Finding includes: During an observation on 11/22/22 at 8:04 a.m., QMA 1 prepared Resident D's morning medications, which were stored in a locked tote in the resident's kitchenette. Resident D was sitting in a recliner in the living area. QMA 1 asked the resident if he had his inhaler (medication	Facility #: 014178 Survey Date: 11/22/2022 Plan of Correction R - 216 Evaluation Noncompliance Corrective Action: 1. No Residents were negatively affected by alleged deficient practice. Licensed nursing was in-serviced 11/22/2022 and 12/01/2022 on conducting assessments for those who self-administer their medication. Resident D was not harmed by not having an order to self-administer medications. Physicians order was obtained for resident D to self-administer Inhaler medication on 12/2/2022. 2. All residents have the potential to be affected with-out	
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for lungs) and he held up the inhaler of Trelegy Ellipta which was located on the table beside the recliner, and indicated he self administered the inhaler.

Resident D's Physician's Orders were reviewed 11/22/22 at 10:37 a.m. A Physician's Order, dated 8/17/21, indicated Trelegy Ellipta 200-62.5 micrograms, inhale one puff by mouth daily at 8 a.m.

Resident D's record was reviewed on 11/22/22 at 12:22 p.m. The diagnoses included, but were not limited to, congestive heart failure.

The Physician's Recapitulation Orders, dated 11/2022, lacked a Physician's Order for self administration of medications.

A Self Administration Assessment, dated 12/13/21, indicated the medications were to be stored and locked in the room and were to be administered by a Licensed Nurse.

A facility Medication Management policy, dated 3/23/22 and received from the Executive Director as current, indicated a Self Administration Assessment would be completed by the Director of Nursing or Licensed Designee to determine what level of assistance was needed for medication administration. The

having an assessment or orders by the MD to assure that the resident is capable of understanding and handling his own medication administration. Audits will be completed by 12/28/2022 by the nursing staff on completed assessment and physician orders for residents that self-administer medications. Assessments and orders will be completed/obtained if needed.

3.
Nursing personnel (RN/LPN's) were re-in-serviced on 12/1/2022 on assuring assessments for those residents who self-administer are accurate with orders to have medication at bedside. New admissions or change of condition on a resident will initiate an assessment to determine if resident is capable of self-administration of medication.

4.
A QA audit will be conducted by the DON /or designee 3 residents, 3 times a week x 4 weeks and then weekly for 8 weeks. Monthly audits will be reviewed at the monthly QA meeting and

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assessment would be completed twice a year and as needed with a change in condition.

Based on observation, record review and interview, the facility failed to ensure a resident was evaluated for self-administration of medications, for 1 of 5 residents observed on a Medication Pass Administration who self-administered medication. (Resident D)

Finding includes:

During an observation on 11/22/22 at 8:04 a.m., QMA 1 prepared Resident D's morning medications, which were stored in a locked tote in the resident's kitchenette. Resident D was sitting in a recliner in the living area. QMA 1 asked the resident if he had his inhaler (medication for lungs) and he held up the inhaler of Trelegy Ellipta which was located on the table beside the recliner, and indicated he self administered the inhaler.

Resident D's Physician's Orders were reviewed 11/22/22 at 10:37 a.m. A Physician's Order, dated 8/17/21, indicated Trelegy Ellipta 200-62.5 micrograms, inhale one puff by mouth daily at 8 a.m.

Resident D's record was reviewed on 11/22/22 at 12:22 p.m. The diagnoses included, but were not limited to,

recommendations will be presented for any need of continued auditing.

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	congestive heart failure. The Physician's Recapitulation Orders, dated 11/2022, lacked a Physician's Order for self administration of medications. A Self Administration Assessment, dated 12/13/21, indicated the medications were to be stored and locked in the room and were to be administered by a Licensed Nurse. A facility Medication Management policy, dated 3/23/22 and received from the Executive Director as current, indicated a Self Administration Assessment would be completed by the Director of Nursing or Licensed Designee to determine what level of assistance was needed for medication administration. The assessment would be completed twice a year and as needed with a change in condition.			
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, record review, and interview, the facility	R 0240	Belvedere Senior Housing Facility #: 014178 Survey Date: 11/22/2022	12/28/2022

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failed to ensure a medication was administered as ordered by a Physician for 1 of 5 residents reviewed for medication administration. (Resident D)

Finding includes:

During an observation on 11/22/22 at 8:04 a.m., QMA 1 prepared Resident D's morning medications, which were stored in a locked tote in the resident's kitchenette. The medications were located in packets from the Pharmacy with the date of 11/22/22 and time of 8 a.m. on the packets. The packets included the following medications:

Allopurinol (uric acid reducer)
100 mg (milligrams), one tablet

Aspirin 81 mg, one tablet

Duloxetine (antidepressant) 60 mg, one capsule

Famotidine (stomach medication) 20 mg, one tablet

Ferrous Sulfate (iron) 325 mg, one tablet

Finasteride (urinary retention medication) 5 mg, one tablet

Furosemide (diuretic) 40 mg, one tablet

Lacosamide (anticonvulsant) 100 mg, one tablet

Plan of Correction

**R - 240 Health Services
Deficiency**

Corrective Action:

1.
No Residents were negatively affected by alleged deficient practice.

Nurse immediately obtained an order from prescribing physician for Resident D's medication (Preservision - supplement). Resident D did not sustain any harm from the alleged deficiency.

2.
All residents had potential to be affected if medication is not given as ordered.

3.
Nursing staff was re-inserviced on the week of 12/1/2022 on assuring the orders for medication are given as prescribed by the

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Potassium (supplement) 20 milliequivalents (meq), one tablet Tamulosin (urinary retention) 0.4 mg, one capsule Vitamin D3 (supplement) 2000 IU (International Units), one tablet Vitamin B12 (supplement) 1000 micrograms, one tablet Resident D's Physician's Orders were reviewed 11/22/22 at 10:37 a.m. A Physician's Order, dated 7/8/22, indicated Preservision (supplement), one capsule was also to be administered at 8 a.m. The Preservision had not been administered. The Director of Nursing was informed of the omission of the medication on 11/22/22 at 10:37 a.m. and no further information was received. A facility Medication Management policy, dated 3/23/22 and received from the Executive Director as current, indicated medication was to be administered as ordered by the Resident's Physician. This State residential finding relates to Complaint IN00383250. Based on observation, record review, and interview, the facility		Resident's physician. The licensed nurse (RN/LPN) are to assure all medications have been ordered and are available to the resident. The QMA will inform nurse of medication not available for nurse to obtain an order for medication not available 4. A QA audit will be conducted by the DON /or designee for 3 residents, 3 times a week x 4 weeks and then weekly for 8 weeks. Monthly audits will be reviewed at the monthly QA meeting and recommendations will be presented for any need of continued auditing. Date of Completion: 12/28/2022	
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failed to ensure a medication was administered as ordered by a Physician for 1 of 5 residents reviewed for medication administration. (Resident D)

Finding includes:

During an observation on 11/22/22 at 8:04 a.m., QMA 1 prepared Resident D's morning medications, which were stored in a locked tote in the resident's kitchenette. The medications were located in packets from the Pharmacy with the date of 11/22/22 and time of 8 a.m. on the packets. The packets included the following medications:

Allopurinol (uric acid reducer)
100 mg (milligrams), one tablet

Aspirin 81 mg, one tablet

Duloxetine (antidepressant) 60 mg, one capsule

Famotidine (stomach medication) 20 mg, one tablet

Ferrous Sulfate (iron) 325 mg, one tablet

Finasteride (urinary retention medication) 5 mg, one tablet

Furosemide (diuretic) 40 mg, one tablet

Lacosamide (anticonvulsant) 100 mg, one tablet

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Potassium (supplement) 20 milliequivalents (meq), one tablet

Tamulosin (urinary retention) 0.4 mg, one capsule

Vitamin D3 (supplement) 2000 IU (International Units), one tablet

Vitamin B12 (supplement) 1000 micrograms, one tablet

Resident D's Physician's Orders were reviewed 11/22/22 at 10:37 a.m. A Physician's Order, dated 7/8/22, indicated Preservision (supplement), one capsule was also to be administered at 8 a.m. The Preservision had not been administered.

The Director of Nursing was informed of the omission of the medication on 11/22/22 at 10:37 a.m. and no further information was received.

A facility Medication Management policy, dated 3/23/22 and received from the Executive Director as current, indicated medication was to be administered as ordered by the Resident's Physician.

This State residential finding relates to Complaint IN00383250.

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R 0246	Health Services - Deficiency 410 IAC 16.2-5-4(e)(6) (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, record review, and interview, the facility failed to ensure PRN (as needed) medications were authorized by an RN or LPN prior to administration for 2 of 5 residents reviewed for PRN Medication Administration. (Residents D and C) Findings included: 1. During an observation on 11/22/22 at 8:04 a.m., QMA 1 prepared Resident D's morning medications, which were stored in a locked tote in the resident's kitchenette. Resident D, who was sitting in a recliner in the living area, indicated a muscle relaxant was needed for back pain. The pain was rated a 6 out of 10. QMA 1 then placed a cyclobenzaprine (muscle relaxant) 5 milligrams (mg), one	R 0246	Belvedere Senior Housing Facility #: 014178 Survey Date: 11/22/2022 Plan of Correction R - 246 Health Services Deficiency Corrective Action: 1. No Residents were negatively affected by alleged deficient practice. QMA 1 was in-serviced on 11/22/2022 receiving authorization from a licensed nurse prior to dispensing PRN medication to resident. Residents D and C were not harmed by the alleged deficiency. 2. All residents had potential to be	12/28/2022
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tablet in the cup with the other medications and then administered the medications.

During an interview at the time of the observation, QMA 1 indicated prior authorization was not required from the nurse since she had access to the medication. The nurse only had to give the authorization if the medication was not stored in the tote box.

Resident D's Physician's Orders were reviewed 11/22/22 at 10:37 a.m. A Physician's Order, dated 7/8/22, indicated cyclobenzaprine 5 mg, one tablet daily as needed.

2. During an observation on 11/22/22 at 8:27 a.m., QMA 1 prepared Resident C's morning medications, which were stored in a locked tote in the resident's kitchenette. Resident C asked for Tylenol due to a headache, which was rated at a 4 out of 10. Tylenol 325 mg, two tablets were added to the morning medications and administered to the resident without prior authorization from a nurse.

Resident C's Physician's Orders were reviewed on 11/22/22 at 10:40 a.m. A Physician's Order, dated 5/31/22, indicated Tylenol, 325 mg, two tablets every six hours as needed for pain.

A Professional Resource, titled,

affected by QMA not receiving authorization prior to dispensing PRN medication to residents.

3.
Nursing staff (RN/LPN and QMA's) was re-inserviced on 12/1/2022 on obtaining prior authorization from licensed nurse prior to dispensing PRN medication to a resident.

4.
A QA audit will be conducted by the DON /or designee 3 times a week x 4 weeks and then weekly for 8 weeks. Monthly audits will be reviewed at the monthly QA meeting and recommendations will be presented for any need of continued auditing.

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"Indiana Law and Rules on Qualified Medication Aides", dated 10/2003, indicated PRN medication may be administered only upon authorization of a licensed nurse or physician.

A facility Medication Management policy, dated 3/23/22 and received from the Executive Director as current, indicated, a PRN medication could be administered by a QMA after prior authorization by the licensed nurse.

Based on observation, record review, and interview, the facility failed to ensure PRN (as needed) medications were authorized by an RN or LPN prior to administration for 2 of 5 residents reviewed for PRN Medication Administration. (Residents D and C)

Findings included:

1. During an observation on 11/22/22 at 8:04 a.m., QMA 1 prepared Resident D's morning medications, which were stored in a locked tote in the resident's kitchenette. Resident D, who was sitting in a recliner in the living area, indicated a muscle relaxant was needed for back pain. The pain was rated a 6 out of 10. QMA 1 then placed a cyclobenzaprine (muscle relaxant) 5 milligrams (mg), one tablet in the cup with the other medications and then

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administered the medications.

During an interview at the time of the observation, QMA 1 indicated prior authorization was not required from the nurse since she had access to the medication. The nurse only had to give the authorization if the medication was not stored in the tote box.

Resident D's Physician's Orders were reviewed 11/22/22 at 10:37 a.m. A Physician's Order, dated 7/8/22, indicated cyclobenzaprine 5 mg, one tablet daily as needed.

2. During an observation on 11/22/22 at 8:27 a.m., QMA 1 prepared Resident C's morning medications, which were stored in a locked tote in the resident's kitchenette. Resident C asked for Tylenol due to a headache, which was rated at a 4 out of 10. Tylenol 325 mg, two tablets were added to the morning medications and administered to the resident without prior authorization from a nurse.

Resident C's Physician's Orders were reviewed on 11/22/22 at 10:40 a.m. A Physician's Order, dated 5/31/22, indicated Tylenol, 325 mg, two tablets every six hours as needed for pain.

A Professional Resource, titled, "Indiana Law and Rules on Qualified Medication Aides",

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	dated 10/2003, indicated PRN medication may be administered only upon authorization of a licensed nurse or physician. A facility Medication Management policy, dated 3/23/22 and received from the Executive Director as current, indicated, a PRN medication could be administered by a QMA after prior authorization by the licensed nurse.			
R 0414	Infection Control - Deficiency 410 IAC 16.2-5-12(k) (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, record review, and interview, the facility failed to ensure a staff member washed their hands or completed hand hygiene as indicated by accepted professional practice, related to hand hygiene during a Medication Pass Observation, for 3 of 5 residents observed. (Residents D, G, and C) Finding includes: During a morning Medication Pass Observation on 11/22/22 from 8:04 a.m. through 8:27 a.m., QMA 1 entered Resident D's room at 8:04 a.m. and	R 0414	Belvedere Senior Housing Facility #: 014178 Survey Date: 11/22/2022 Plan of Correction R -414 Infection Control Deficiency Corrective Action: 1. No Residents were negatively affected by alleged deficient practice. QMA 1	12/28/2022

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prepared and administered his morning medications.

QMA 1 then entered Resident G's room at 8:21 a.m., and prepared and administered the morning medications.

QMA 1 then entered Resident C's room at 8:27 a.m., and prepared and administered the morning medications.

Hand hygiene had not been completed prior to and after each medication administration.

During an interview on 11/22/22 at 8:31 a.m., QMA 1 indicated she usually had an alcohol based hand gel with her. She acknowledged hand hygiene had not been completed before and after each medication administration.

A facility policy on Hand Hygiene, dated 10/26/22 and received from the Executive Director as current, indicated an alcohol based hand rub would be used before preparing or handling medications and before and after direct contact with the residents.

Based on observation, record review, and interview, the facility failed to ensure a staff member washed their hands or completed hand hygiene as indicated by accepted professional practice, related to hand hygiene during a

was in-serviced on 11/22/2022 on hand hygiene practices prior to conducting medication pass.

Residents D, G, and C were not harmed by the alleged deficiency.

2.
All residents have the potential to be affected by nursing staff not conducting hand hygiene prior to medication pass.

3.
Nursing staff were in-serviced on 12/1/2022 for hand hygiene and the use of alcohol-based hand rubs (containing 60 to 95 % ethanol or isopropanol) before preparing or handling medications per policy.

4.
A QA audit will be conducted by the DON /or designee 3 times a week x 4 weeks and then weekly for 8 weeks. Monthly audits will be reviewed at the monthly QA meeting and recommendations will be

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Medication Pass Observation,
for 3 of 5 residents observed.
(Residents D, G, and C)

Finding includes:

During a morning Medication
Pass Observation on 11/22/22
from 8:04 a.m. through 8:27
a.m., QMA 1 entered Resident
D's room at 8:04 a.m. and
prepared and administered his
morning medications.

QMA 1 then entered Resident
G's room at 8:21 a.m., and
prepared and administered the
morning medications.

QMA 1 then entered Resident
C's room at 8:27 a.m., and
prepared and administered the
morning medications.

Hand hygiene had not been
completed prior to and after
each medication administration.

During an interview on 11/22/22
at 8:31 a.m., QMA 1 indicated
she usually had an alcohol
based hand gel with her. She
acknowledged hand hygiene
had not been completed before
and after each medication
administration.

A facility policy on Hand
Hygiene, dated 10/26/22 and
received from the Executive
Director as current, indicated an
alcohol based hand rub would
be used before preparing or
handling medications and

presented for any need of
continued auditing.

Date of Completion: 12/28/2022

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FORM APPROVED

OMB NO. 0938-0391

	before and after direct contact with the residents.			
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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