STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE WOODS OF NOBLESVILLE	9600 E 146TH STREET, NOBLESVILLE, , 46060

(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 IN00360659. Complaint IN00360659- Substantiated. State deficiencies related to the allegations are cited at R0052, R0242, and R0247. Unrelated deficiencies cited. Survey dates: August 23 and 24, 2021 Facility number: 014213 Residential Census: 120 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 30, 2021	R 0000	Disclaimer: The submission of this plan of correction does not indicate an admission by Heritage Woods of Noblesville that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and living environment provided to the residents of Heritage Woods of Noblesville. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirement of participation for Assisted Living Facilities. To this end, the plan of correction shall serve as the credible allegation of compliance with all stated and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance.	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6)	R 0052	**R 052**	09/23/2021

	(v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, failed to ensure a resident was free from unwelcome sexual advancement by another resident that resided in the facility. (Resident B) Findings include: During a telephone interview 8/24/21 at 12:21 p.m., a family member of Resident B indicated they would often visit, and staff would direct them to his room and said they would bring him to his room. He was often found in Resident C's room. During one visit, family was adamant about going with staff to find the resident and he was found in the female resident's room. Staff knew where the resident was, and the family were asked by the Memory Care Director and Administrator to allow the relationship to happen and not intervene. They understood the diagnosis of dementia, but felt		1) The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident B no longer resides at the community and was relocated to an alternate care setting and resident C continues to resident at the community with no further incidents. 2)How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken: A review was completed of clinical notes and no sexual advances were noted. 3)The measures put in place and systemic changes the facility will make to ensure that the alleged deficient practice does not recur: A) Memory Care staff will be in-serviced on behavior treatment of sexually motivated interaction between residents by the Memory Care Director or designee by September 23, 2021 B) Nursing staff will be in-serviced by the Memory Care Director and/or designee by September 23, 2021 on physician and family notification of sexual behaviors	

	the relationship was inappropriate. 1. The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. The most recent service plan, dated 3/24/21, indicated the resident had severely impaired decision-making skills and his ability to express himself was limited. A Saint Louis University Mental Status Examination (method of screening for Alzheimer's disease) indicated Resident B had a total score of 1. A score of 1-20 indicated a diagnosis of dementia. A progress note, dated 3/22/21 at 6:05 p.m., indicated the resident had become close with a female resident. The female resident followed him around and Resident B kissed her on the lips. Families were made aware. On 4/3/21 at 6:28 p.m., Resident B was seen walking into a room with the female resident. Resident B was redirected back to his room and provided a snack The Administrator and family were		immediately and document their response regarding resident interaction, in order to have written confirmation of family wishes and MD orders obtained; C) Private duty or family sitter will be arranged to prevent unwanted sexual interaction until behavior is no longer present or alternative living arrangements are made. D) All new MC staff will be educated on resident rights/abuse & neglect and interventions to protect against sexually motivated contact between residents during initial orientation. 4)The corrective action will be monitored to ensure the alleged deficient practice will not recur: A) Memory Care Director or designee will review clinical documentation for any resident exhibiting sexual motivated behaviors 5 x weekly for 4 weeks, weekly x 3 months, then bi-monthly x 3 months; B) Any resident exhibiting sexually aggressive behavior will be reviewed by physician, medications evaluated for any necessary changes and family made aware with response documented and ensure a private duty or family sitter will be arranged immediately for any	

	notified. On 4/5/21 at 2:49 p.m., staff had made attempts to separate the residents, but they believed they were married. Resident B's wife was notified and was not upset with the friendship but requested to keep them from kissing or becoming sexually involved. A progress note, dated 4/6/21 at 11:49 p.m., indicated around 8:00 p.m. both residents were in the female resident's room. Resident B became angry and aggressive with staff when they tried to redirect him to his room. Approximately 10:30 p.m., Resident B was in the female resident's room, and they were both naked in bed laying side by side. The QMA was able to get the female resident dressed and escorted Resident B back to his room. The Administrator was notified of the incident. On 4/7/21 at 11:21 a.m., a progress note indicated both residents were possessive of one another and had been caught sneaking into each other's room. At 9:44 a.m., Resident B was found in the female resident's room. Both residents were on her bed, partially clothed. When staff attempted to redirect Resident B, he became angry and threatened to kill them. The resident raised his fists, was		resident exhibiting sexually motivated behaviors; C) Quarterly QA committee will review audits and make recommendations for ongoing need for audits. 5) The date the systemic changes will be completed: 9/23/2021. .	

shaking and had red face and proceeded to slamm doors.

On 4/7/21 at 6:35 p.m., a progress note indicated Resident B referred to the female resident as his best friend and stated they had been together for years.

2. The clinical record for Resident C was reviewed on 8/23/21 at 2:10 p.m. Diagnoses included, but were not limited to, atrial fibrillation, agitation and hypertension.

On 8/5/19, Resident C was prescribed Seroquel (antipsychotic medication) 25 mg, 1/2 tablet at night and tablet every 4 hours for agitation.

A service plan, dated 3/19/21, indicated the resident got frustrated at times and would make sexual comments. The resident also had manipulative behaviors and delusional thoughts. Services included to provide redirection, decrease stimuli and keep physician up to date.

A progress note, dated 3/22/21 at 5:32 p.m., indicated the resident had become close with a male resident. She followed him around and Resident B kissed her on the lips. Families were made aware.

On 4/2/21 at 1:28 a.m., Resident C was seen walking

with a male resident heading towards his room. The resident has been redirected and given Seroquel for agitation.

On 4/5/21 at 2:50 p.m., staff had made attempts to separate the residents, but they believed they were married. Resident C's daughter was aware of the situation and stated she would not be upset if they held hands and spent time together. The daughter requested they keep them from becoming sexually involved.

On 4/7/21 at 6:35 p.m., a progress note indicated Resident C becomes very agitated when they separate her from Resident B. She would quickly seek him out and stand close to him. She indicated he was her "husband."

A progress note, dated 4/14/21 at 6:27 a.m., indicated the resident has been up all during the shift, lurking outside her door.

On 4/30/21 at 8:09 p.m., resident very suspicious and angry and would not eat or take her routine medications. She was still looking for her husband.

During an interview on 8/24/21 at 1:37 p.m., the Administrator indicted staff were to monitor and provide different activities. She was not aware of what the

	families wanted but had talked to them about the relationship. She was unaware there had been no medication adjustments made for Resident C or the physician was made aware of the situation. She indicated they often had 2 to 3 staff during third shift on the locked unit and sometimes 4 or 5 depending on who was available. Review of the staff schedule for 8/24/21, the Memory Care Unit had 1 QMA and 1 CNA scheduled. Review of a facility policy dated 2/2018 and titled "Abuse, Neglect and Financial Exploitation Prevention Policy and Procedures", provided by the Director of Nursing on 8/23/21 at 10:55 a.m., indicated the following: "Residents of The Facility have the right to be free of abuse, neglect.... ...The facility will make every effort to prevent abuse, neglect...." This State tag relates to Complaint IN00360659.			

	Based on interview and record review, failed to ensure a resident was free from unwelcome sexual advancement by another resident that resided in the facility. (Resident B) Findings include: During a telephone interview 8/24/21 at 12:21 p.m., a family member of Resident B indicated they would often visit, and staff would direct them to his room and said they would bring him to his room. He was often found in Resident C's room. During one visit, family was adamant about going with staff to find the resident and he was found in the female resident's room. Staff knew where the resident was, and the family were asked by the Memory Care Director and Administrator to allow the relationship to happen and not intervene. They understood the diagnosis of dementia, but felt the relationship was inappropriate. 1. The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. The most recent service plan,			

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On 4/3/21 at 6:28 p.m., Resident B was seen walking into a room with the female resident. Resident B was redirected back to his room and provided a snack The Administrator and family were notified.

On 4/5/21 at 2:49 p.m., staff had made attempts to separate the residents, but they believed they were married. Resident B's wife was notified and was not upset with the friendship but requested to keep them from kissing or becoming sexually involved.

A progress note, dated 4/6/21 at 11:49 p.m., indicated around

	8:00 p.m. both residents were in the female resident's room. Resident B became angry and aggressive with staff when they tried to redirect him to his room. Approximately 10:30 p.m., Resident B was in the female resident's room, and they were both naked in bed laying side by side. The QMA was able to get the female resident dressed and escorted Resident B back to his room. The Administrator was notified of the incident. On 4/7/21 at 11:21 a.m., a progress note indicated both residents were possessive of one another and had been caught sneaking into each other's room. At 9:44 a.m., Resident B was found in the female resident's room. Both residents were on her bed, partially clothed. When staff attempted to redirect Resident B, he became angry and threatened to kill them. The resident raised his fists, was shaking and had red face and proceeded to slamm doors. On 4/7/21 at 6:35 p.m., a progress note indicated Resident B referred to the female resident as his best friend and stated they had been together for years. 2. The clinical record for Resident C was reviewed on 8/23/21 at 2:10 p.m. Diagnoses included, but were not limited to,			

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A progress note, dated 4/14/21 at 6:27 a.m., indicated the resident has been up all during the shift, lurking outside her door.

On 4/30/21 at 8:09 p.m., resident very suspicious and angry and would not eat or take her routine medications. She was still looking for her husband.

During an interview on 8/24/21 at 1:37 p.m., the Administrator indicted staff were to monitor and provide different activities. She was not aware of what the families wanted but had talked to them about the relationship. She was unaware there had been no medication adjustments made for Resident C or the physician was made aware of the situation. She indicated they often had 2 to 3 staff during third shift on the locked unit and sometimes 4 or 5 depending on who was available.

Review of the staff schedule for 8/24/21, the Memory Care Unit

	had 1 QMA and 1 CNA scheduled. Review of a facility policy dated 2/2018 and titled "Abuse, Neglect and Financial Exploitation Prevention Policy and Procedures", provided by the Director of Nursing on 8/23/21 at 10:55 a.m., indicated the following: "Residents of The Facility have the right to be free of abuse, neglect.... ...The facility will make every effort to prevent abuse, neglect...." This State tag relates to Complaint IN00360659.			
R 0242	Health Services - Offense 410 IAC 16.2-5-4(e)(2) (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on interview and record review, the facility failed to administer medications, notify the physician or monitor for side effects following the medication error for 1 of 3 residents	R 0242	**R 242** 1)The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident B no longer resides at the community. 2) How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken: No other residents were affected by alleged deficient practice as Memory Care Director	09/23/2021

	reviewed for medication side effects (Resident B). Findings include: The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. The most recent service plan indicated the resident required medication administration and management with his medication regiment. Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21 and discharged to the hospital on 4/27/21 at 3:00 p.m. Review of the April Medication Administration Record (MAR), the facility failed to administer the following medications: a. Celexa (antidepressant) 10 mg daily - 4/22/21 through 4/27/21. b. Aricept (to treat the symptoms of dementia) 10 mg daily - 4/22/21 through 4/26/21. c. Zestril (to treat high blood		completed a review of new medication orders for last 30 days. 3)The measures put in place and systemic changes the facility will make to ensure that the alleged deficient practice does not recur; A) All licensed nursing staff will be educated by Director of Nursing on process of handling new medication orders and medication error policy by September 23, 2021; B) New medication orders will be placed in 24-hour binder after faxing to pharmacy, the following shift with nurse coverage will be responsible for reconciling EMAR and add new medication order for administration; C) Nursing staff will notify Director of Nursing of any issues with new medication orders as well as document on 24-hour report sheet. 4) The corrective action will be monitored to ensure the alleged deficient practice will not re cur: A) Memory Care Director and/or designee will audit new medication orders daily x 8 weeks, then weekly for 8 weeks, bi-weekly x 2 months and then monthly on-going to ensure new medication orders are on active EMAR and medication is available for medication administration; B)	

	pressure) 20 mg twice daily - 4/22/21 through 4/26/21 morning dose. d. Namenda (to treat moderate to severe confusion) 10 mg twice daily - 4/22/21 through 4/27/21. e. Risperdal (antipsychotic medication) 0.25 mg twice daily - 4/22/21 through 4/27/21. f. Zocor (treat high cholesterol) 40 mg at night - 4/22/21 through 4/26/21. A progress note, dated 4/26/21 at 7:18 p.m., indicated the resident's blood pressure was checked due to the delay in medication order being added to the Electronic Medication Administration Record (EMAR). The resident's vital signs included a blood pressure of 120/78, pulse 85 and oxygen saturation 95%. A family member was concerned about the medications not being given and the palliative care company was contacted to discuss the medications and sedation level. On 4/27/21 at 3:00 p.m., a progress note indicated the resident was sent to the hospital related to altered mental status. During an interview on 8/24/21 at 9:50 a.m., LPN 1 indicated when the resident readmitted on 4/22/21, his medications were not restarted. The nurses' do		Audits and Medication error reports will be reviewed during Quarterly QA meetings and if no issues identified, evaluate the need for ongoing audits. 5)The date the systemic changes will be completed: 9/23/2021.	

not enter any orders but send them to the pharmacy and they enter the orders. Someone failed to fax the order to the pharmacy, so the medications were not given.

Review of a current undated facility policy, titled "Medication Error", provided by the Administrator on 8/24/21 at 1:45 p.m., indicated the following:

"The community will follow the guidelines for medication assistance....

...2. ALL medication errors that occur for residents receiving medication management services from the community are required to be recorded....

...3. A medication error includes:

wrong medication

wrong dose

wrong time

wrong route

missed medication.

4. The HFA Medication Error Report form must be completed each time an error is discovered. ALL medications involved in the incident must be listed on the second page of the report form...."

This State tag relates to

Complaint IN00360659.

Based on interview and record review, the facility failed to administer medications, notify the physician or monitor for side effects following the medication error for 1 of 3 residents reviewed for medication side effects (Resident B).

Findings include:

The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility.

The most recent service plan indicated the resident required medication administration and management with his medication regiment.

Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21 and discharged to the hospital on 4/27/21 at 3:00 p.m.

Review of the April Medication Administration Record (MAR), the facility failed to administer the following medications:

a. Celexa (antidepressant) 10

	mg daily - 4/22/21 through 4/27/21. b. Aricept (to treat the symptoms of dementia) 10 mg daily - 4/22/21 through 4/26/21. c. Zestril (to treat high blood pressure) 20 mg twice daily - 4/22/21 through 4/26/21 morning dose. d. Namenda (to treat moderate to severe confusion) 10 mg twice daily - 4/22/21 through 4/27/21. e. Risperdal (antipsychotic medication) 0.25 mg twice daily - 4/22/21 through 4/27/21. f. Zocor (treat high cholesterol) 40 mg at night - 4/22/21 through 4/26/21. A progress note, dated 4/26/21 at 7:18 p.m., indicated the resident's blood pressure was checked due to the delay in medication order being added to the Electronic Medication Administration Record (EMAR). The resident's vital signs included a blood pressure of 120/78, pulse 85 and oxygen saturation 95%. A family member was concerned about the medications not being given and the palliative care company was contacted to discuss the medications and sedation level. On 4/27/21 at 3:00 p.m., a progress note indicated the			

resident was sent to the hospital related to altered mental status.

During an interview on 8/24/21 at 9:50 a.m., LPN 1 indicated when the resident readmitted on 4/22/21, his medications were not restarted. The nurses' do not enter any orders but send them to the pharmacy and they enter the orders. Someone failed to fax the order to the pharmacy, so the medications were not given.

Review of a current undated facility policy, titled "Medication Error", provided by the Administrator on 8/24/21 at 1:45 p.m., indicated the following:

"The community will follow the guidelines for medication assistance....

...2. ALL medication errors that occur for residents receiving medication management services from the community are required to be recorded....

...3. A medication error includes:

wrong medication

wrong dose

wrong time

wrong route

missed medication.

4. The HFA Medication Error

	Report form must be completed each time an error is discovered. ALL medications involved in the incident must be listed on the second page of the report form...." This State tag relates to Complaint IN00360659.			
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 record review and interview, the facility failed to document authorization to administer as needed (PRN) medications in the nursing notes for 1 of 3 residents reviewed for PRN medications. (Resident B) Findings include: The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were	R 0246	**R 246** 1)The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice: Resident B no longer resides at the community. 2)How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken: No other residents were identified to be affected by alleged deficient practice. Memory Care Director completed a review of PRN medications for the last 30 days to ensure that appropriate authorization was given for administered PRN medications. 3)The measures put in place and systemic changes the facility will	09/23/2021

	not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. The most recent service plan indicated the resident required medication administration and management with his medication regiment. Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21. Review of an order, dated 4/23/21, indicated to administer lorazepam (antianxiety) 2 mg/mL 4 times daily as needed for restlessness. Review of a Narcotic Inventory Sheet, dated 4/24/21, indicated lorazepam; dosage 0.5 mL. On 4/24/21, Qualified Medication Aide (QMA) 3 administered the medication at 1:00 p.m., 4:00 p.m. and 8:00 p.m. QMA 4 administered lorazepam on 4/25/21 at 12:45 a.m. and 6:00 a.m. QMA 5 administered the medication on 4/25/21 at 4:30 p.m. and 8:30 p.m. On 4/26/21, a new order was received to give lorazepam 0.5 mL four times daily routinely. During an interview on 8/24/21 at 9:50 a.m., LPN 1 indicated the QMAs should put the initials		make to ensure that the alleged deficient practice does not recur: Director of Nursing will in-service QMA's by September 23, 2021, on required documentation in nurses notes when nurse is not on premise for authorization. 4)The corrective action will be monitored to ensure the alleged deficient practice will not re cur: Memory Care Director or designee will review PRN medications administered and appropriate documentation of licensed nurse approval when not on premise 5 x weekly x 4 weeks, weekly x 3 months, bi-weekly x 3 months and then monthly on-going; C) All newly hired QMA's will receive training on licensed nurse approval and appropriate documentation required when nurse not on premises during orientation; and C) Quarterly QA committee will review audits of medication administration and QMA documentation of licensed nurse approval and if no issues identified, evaluate need for ongoing audits. 5)The date the systemic changes will be completed: 9/23/2021.	

of the nurse who authorized the PRN medication on the PRN report. She was unable to find any authorization of the medication administration. She was unsure why the lorazepam had two different directions for administration.

Review of a current undated policy, titled "Medication Oversight, Administration, Storage", provided by the Administrator on 8/24/21 at 3:37 p.m., indicated the following:

"PURPOSE:

The purpose of this policy is to ensure that the resident's safety is maintained....

...g. PRN medications: As needled medication may be administered by a licensed personnel. A qualified medication aide (QMA) can administer as needed medications only upon the authorization by a licensed nurse...."

Based on record review and interview, the facility failed to document authorization to administer as needed (PRN) medications in the nursing notes for 1 of 3 residents reviewed for PRN medications. (Resident B)

Findings include:

The closed clinical record for Resident B was reviewed on

	8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. The most recent service plan indicated the resident required medication administration and management with his medication regiment. Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21. Review of an order, dated 4/23/21, indicated to administer lorazepam (antianxiety) 2 mg/mL 4 times daily as needed for restlessness. Review of a Narcotic Inventory Sheet, dated 4/24/21, indicated lorazepam; dosage 0.5 mL. On 4/24/21, Qualified Medication Aide (QMA) 3 administered the medication at 1:00 p.m., 4:00 p.m. and 8:00 p.m. QMA 4 administered lorazepam on 4/25/21 at 12:45 a.m. and 6:00 a.m. QMA 5 administered the medication on 4/25/21 at 4:30 p.m. and 8:30 p.m. On 4/26/21, a new order was received to give lorazepam 0.5 mL four times daily routinely. During an interview on 8/24/21			

	at 9:50 a.m., LPN 1 indicated the QMAs should put the initials of the nurse who authorized the PRN medication on the PRN report. She was unable to find any authorization of the medication administration. She was unsure why the lorazepam had two different directions for administration. Review of a current undated policy, titled "Medication Oversight, Administration, Storage", provided by the Administrator on 8/24/21 at 3:37 p.m., indicated the following: "PURPOSE: The purpose of this policy is to ensure that the resident's safety is maintained.... ...g. PRN medications: As needled medication may be administered by a licensed personnel. A qualified medication aide (QMA) can administer as needed medications only upon the authorization by a licensed nurse...."			
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7) (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when	R 0247	**R 247** 1)The corrective action that will be accomplished for those residents found to have been affected by the alleged	09/23/2021

	there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to ensure a medication error was documented in the clinical record and the physician was notified of any potential side-effects from the error for 1 of 3 residents reviewed for medication administration. (Resident B) Findings include: The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. The most recent service plan indicated the resident required medication administration and management with his medication regiment. Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21 and discharged to the hospital on 4/27/21 at 3:00 p.m. Review of the April Medication Administration Record (MAR), the facility failed to administer		deficient practice: Resident B no longer resides at the community. 2)How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken: No other residents were affected by the alleged deficient practice. 3)The measures put in place and systemic changes the facility will make to ensure that the alleged deficient practice does not recur: A) Director of Nursing will in-service licensed nurses by September 23, 2021, on documentation of medication errors including notification of physician; B) New hired licensed nurses will receive training on documentation of med errors including notification of physician during orientation. 4)The corrective action will be monitored to ensure the alleged deficient practice will not re cur: A) Memory Care Director or designee will audit the incident log weekly x 4 weeks, bi-monthly x 8 weeks, monthly x 3 months and then quarterly on-going for required	

	the following medications: a. Celexa (antidepressant) 10 mg daily - 4/22/21 through 4/27/21. b. Aricept (to treat the symptoms of dementia) 10 mg daily - 4/22/21 through 4/26/21. c. Zestril (to treat high blood pressure) 20 mg twice daily - 4/22/21 through 4/26/21 morning dose. d. Namenda (to treat moderate to severe confusion) 10 mg twice daily - 4/22/21 through 4/27/21. e. Risperdal (antipsychotic medication) 0.25 mg twice daily - 4/22/21 through 4/27/21. f. Zocor (treat high cholesterol) 40 mg at night - 4/22/21 through 4/26/21. A progress note, dated 4/23/21 at 11:31 a.m., indicated the facility called the physician to "discuss issues." The physician indicated to send the resident to the Emergency Room (ER) and add Zyprexa (antipsychotic) to his allergy list.		documentations of medication errors, including physician notification, B) Quarterly QA committee will review documentation of medication errors and notification and no issues noted, make recommendations for need of continued audits. 5)The date the systemic changes will be completed: 9/23/2021	

	A note, dated 4/23/21 at 11:44 a.m., indicated the family was not in agreement with sending the resident to the ER due to recent environmental changes and would be at the facility soon. A progress note, dated 4/25/21 at 6:06 a.m., indicated the resident had been restless and aggressive. On 4/26/21 at 6:09 a.m., the resident was noted to be restless and attempting to get out of bed. A progress note, dated 4/26/21 at 3:16 p.m., indicated the resident returned to the facility "barely alert and disoriented x 4." The resident was unable to verbalize or follow commands. On 4/26/21 at 3:20 p.m., a note indicated the physician requested to send the resident to the ER for evaluation for physical and mental decline. The family was reluctant due to recent changes. A progress note, dated 4/26/21 at 7:18 p.m., indicated the resident's blood pressure was checked due to the delay in medication order being added to the Electronic Medication Administration Record (EMAR). The resident's vital signs included a blood pressure of 120/78, pulse 85 and oxygen saturation 95%. A family			

member was concerned about the medications not being given and the palliative care company was contacted to discuss the medications and sedation level.

On 4/27/21 at 1:20 a.m., Resident B was found on the floor near his bed. The resident was aggressive and receive Ativan (antianxiety) for discomfort and restlessness.

On 4/27/21 at 3:00 p.m., a progress note indicated the resident was sent to the hospital related to altered mental status.

A progress note dated 4/27/21 at 5:01 p.m., the Administrator indicated the family requested the resident be sent to the ER.

During an interview on 8/24/21 at 9:50 a.m., LPN 1 indicated when the resident readmitted on 4/22/21, his medications were not restarted. The nurses' do not enter any orders but send them to the pharmacy and they enter the orders. Someone failed to fax the order to the pharmacy, so the medications were not given.

The clinical record lacked any documentation the physician was notified of the medication error.

Review of a current undated facility policy, titled "Medication Error", provided by the Administrator on 8/24/21 at 1:45

	p.m., indicated the following: "The community will follow the guidelines for medication assistance.... ...2. ALL medication errors that occur for residents receiving medication management services from the community are required to be recorded.... ...3. A medication error includes: wrong medication wrong dose wrong time wrong route missed medication. 4. The HFA Medication Error Report form must be completed each time an error is discovered. ALL medications involved in the incident must be listed on the second page of the report form...." This State tag relates to Complaint IN00360659. Based on interview and record review, the facility failed to ensure a medication error was documented in the clinical record and the physician was notified of any potential side-effects from the error for 1 of 3 residents reviewed for medication administration.			

(Resident B)

Findings include:

The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility.

The most recent service plan indicated the resident required medication administration and management with his medication regiment.

Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21 and discharged to the hospital on 4/27/21 at 3:00 p.m.

Review of the April Medication Administration Record (MAR), the facility failed to administer the following medications:

a. Celexa (antidepressant) 10 mg daily - 4/22/21 through 4/27/21.

b. Aricept (to treat the symptoms of dementia) 10 mg daily - 4/22/21 through 4/26/21.

c. Zestril (to treat high blood pressure) 20 mg twice daily - 4/22/21 through 4/26/21

morning dose.

d. Namenda (to treat moderate to severe confusion) 10 mg twice daily - 4/22/21 through 4/27/21.

e. Risperdal (antipsychotic medication) 0.25 mg twice daily - 4/22/21 through 4/27/21.

f. Zocor (treat high cholesterol) 40 mg at night - 4/22/21 through 4/26/21.

A progress note, dated 4/23/21 at 11:31 a.m., indicated the facility called the physician to "discuss issues." The physician indicated to send the resident to the Emergency Room (ER) and add Zyprexa (antipsychotic) to his allergy list.

A note, dated 4/23/21 at 11:44 a.m., indicated the family was not in agreement with sending the resident to the ER due to recent environmental changes and would be at the facility soon.

A progress note, dated 4/25/21 at 6:06 a.m., indicated the resident had been restless and aggressive.

On 4/26/21 at 6:09 a.m., the resident was noted to be restless and attempting to get out of bed.

A progress note, dated 4/26/21 at 3:16 p.m., indicated the

resident returned to the facility "barely alert and disoriented x 4." The resident was unable to verbalize or follow commands.

On 4/26/21 at 3:20 p.m., a note indicated the physician requested to send the resident to the ER for evaluation for physical and mental decline. The family was reluctant due to recent changes.

A progress note, dated 4/26/21 at 7:18 p.m., indicated the resident's blood pressure was checked due to the delay in medication order being added to the Electronic Medication Administration Record (EMAR). The resident's vital signs included a blood pressure of 120/78, pulse 85 and oxygen saturation 95%. A family member was concerned about the medications not being given and the palliative care company was contacted to discuss the medications and sedation level.

On 4/27/21 at 1:20 a.m., Resident B was found on the floor near his bed. The resident was aggressive and receive Ativan (antianxiety) for discomfort and restlessness.

On 4/27/21 at 3:00 p.m., a progress note indicated the resident was sent to the hospital related to altered mental status.

A progress note dated 4/27/21 at 5:01 p.m., the Administrator

indicated the family requested the resident be sent to the ER.

During an interview on 8/24/21 at 9:50 a.m., LPN 1 indicated when the resident readmitted on 4/22/21, his medications were not restarted. The nurses' do not enter any orders but send them to the pharmacy and they enter the orders. Someone failed to fax the order to the pharmacy, so the medications were not given.

The clinical record lacked any documentation the physician was notified of the medication error.

Review of a current undated facility policy, titled "Medication Error", provided by the Administrator on 8/24/21 at 1:45 p.m., indicated the following:

"The community will follow the guidelines for medication assistance....

...2. ALL medication errors that occur for residents receiving medication management services from the community are required to be recorded....

...3. A medication error includes:

wrong medication

wrong dose

wrong time

	wrong route missed medication. 4. The HFA Medication Error Report form must be completed each time an error is discovered. ALL medications involved in the incident must be listed on the second page of the report form...." This State tag relates to Complaint IN00360659.			
R 0410	Infection Control - Noncompliance 410 IAC 16.2-5-12(e)(f)(g) (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have	R 0410	**R 410** 1)The corrective action that will be accomplished for those residents found to have been affected by the alleged deficient practice: Documentation of 1st step PPD given on 3/17/2021 was located for Resident B. Resident B no longer resides at the community. 2) How the facility will identify other residents having the potential to be affected by the alleged deficient practice and the corrective action that will be taken: A) All newly admitted residents have potential to be affected by alleged deficient practice; B) Memory Care Director completed an audit of resident records to	09/23/2021

	a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure residents received a tuberculin (TB) test on or prior to admission for 1 of 3 residents reviewed for TB testing. (Resident B) Findings include: The closed clinical record for Resident B was reviewed on 8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21 and discharged to the hospital on 4/27/21 at 3:00 p.m. Review of a Tuberculosis Skin Test Screening Record dated 4/26/21 at 12:00 p.m., the resident received the first dose of Tubersol (test used to detect test used to detect tuberculosis) by the Memory Care Director (MCD). A progress note by the MCD, dated 4/26/21 at 3:32 p.m.,		determine any other residents who did not have documentation of a two-step PPD, if record found deficient, resident PPD test to be completed. 3)The measures put in place and systemic changes the facility will make to ensure that the alleged deficient practice does not recur: Memory Care Director to in-service nurses on PPD testing policy by September 23, 2021. 4)The corrective action will be monitored to ensure the alleged deficient practice will not re cur: A) Memory Care Director and/or designee will audit new admission resident records 48-72 hours after admission for proper documentation of PPD administered test; B) Quarterly QA committee to review audits of PDD documentation monthly x 6 months and on-going, to make further recommendations on additional training/need for continued audits. 5)The date the systemic changes will be completed: 9/23/2021.	

indicated the resident received Tubersol and tolerated well.

During an interview on 8/24/21 at 10:11 a.m., LPN 2 indicated a lot of things have been missed with all the staff changes.

The MCD was unavailable for an interview.

Review of a current undated facility policy, titled "Infection Prevention & Control", provided by the Administrator on 8/24/21 at 1:45 p.m., indicated the following:

"PURPOSE:

To minimize the risk of transmission of infection to staff members and residents.

POLICY:

It is the policy of this community to prevent and/or minimize the spread of infectious diseases through infection control practices...."

Based on record review and interview, the facility failed to ensure residents received a tuberculin (TB) test on or prior to admission for 1 of 3 residents reviewed for TB testing. (Resident B)

Findings include:

The closed clinical record for Resident B was reviewed on

	8/23/21 at 11:37 a.m. Diagnoses included, but were not limited to, dementia with behavioral disturbances, hypertension, history of malignant neoplasm of prostate and physical debility. Resident B admitted to the facility on 3/17/21 and discharged to a hospital on 4/8/21. The resident readmitted to the facility on 4/22/21 and discharged to the hospital on 4/27/21 at 3:00 p.m. Review of a Tuberculosis Skin Test Screening Record dated 4/26/21 at 12:00 p.m., the resident received the first dose of Tubersol (test used to detect test used to detect tuberculosis) by the Memory Care Director (MCD). A progress note by the MCD, dated 4/26/21 at 3:32 p.m., indicated the resident received Tubersol and tolerated well. During an interview on 8/24/21 at 10:11 a.m., LPN 2 indicated a lot of things have been missed with all the staff changes. The MCD was unavailable for an interview.			

	Review of a current undated facility policy, titled "Infection Prevention & Control", provided by the Administrator on 8/24/21 at 1:45 p.m., indicated the following: "PURPOSE: To minimize the risk of transmission of infection to staff members and residents. POLICY: It is the policy of this community to prevent and/or minimize the spread of infectious diseases through infection control practices...."			

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