STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OASIS AT 56TH	4940 WEST 56TH STREET, INDIANAPOLIS, , 46254

(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 IN00359411 and IN00359262. Complaint IN00359411 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00359262 - Substantiated. State Residential Finding related to the allegations are cited at R0214, R0217, R0295, R0296, R0301, R0302 and R0349. Unrelated deficiency is cited. Survey dates: August 2, 3 and 4, 2021 Facility number: 014279 Residential Census: 111 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Complaints (IN00359262, IN00359411) August 4, 2021 I would respectively request a desk review.	

	Quality review completed on August 10, 2021			
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure 3 of 4 residents reviewed for falls and anticoagulant use had evaluations reflect these issues. (Resident C, D and E) Findings include: 1. The clinical record of Resident C was reviewed on 8-2-21 at 12:16 p.m. His diagnoses included, but was not limited to, cerebrovascular disease, hypertension, diabetes with neuropathy, joint pain and unsteadiness on his feet. It indicated a fall risk assessment was conducted on 12-2-20, indicating he was at high risk for falls. A general assessment was conducted on 12-2-20, which indicated he uses a walker and has some cognitive issues when	R 0214	-**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C discharged from community on 8/01/2021. Resident D service plan was reviewed by DON and updated to reflect high fall risk and the use of anticoagulants. Resident E service plan was reviewed by DON and updated to reflect high fall risk and the use of anticoagulants. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All other residents had the potential to be affected by this deficient practice. Service plans	08/26/2021

	in new situations. The clinical record indicated an evaluation of the resident was conducted on 3-13-21. Review of the service plans, most recently updated on 8-11-20 and 12-18-20, failed to reflect any concerns with Resident C being a high fall risk. In an interview with a family member on 8-2-21 at 1:57 p.m., she indicated Resident C had a fall in his room on 7-27-21, resulting in a hospitalization. As of 8-2-21, he remained in the hospital. 2. The clinical record of Resident D was reviewed on 8-4-21 at 11:01 a.m. Her diagnoses included, but were not limited to morbid obesity and a history of substance dependency. A "SLUMS" (St. Louis University Mental Status exam for dementia) indicated she scored within the normal range on her preadmission evaluation, conducted 6-3-21. A fall risk assessment, conducted on 4-23-21, on a preadmission evaluation indicated she was a high fall risk and that she had experienced falls in the last 6 months. Review of her medications indicated she was physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident D has had a minimum of 3 falls since she admitted to		were audited on 8/6/2021 by the DON and then updated as needed to ensure that every resident's service plan reflects their plan of care. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON educated nursing staff on 8/6/2021 on the importance ensuring all service plans reflect the residents plan of care and to ensure the service plans get updated as needed. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then	

	the facility on 6-5-21. Review of her initial service plan, dated 6-4-21, did not reflect either concern related to being a high fall risk or the use of an anticoagulant. 3. The clinical record of Resident E was reviewed on 8-4-21 at 11:45 a.m. Her diagnoses included, but were not limited to, intracardiac thrombosis (blood clot in the heart), hypertension, peripheral vascular disease, coronary artery disease and Hepatitis C. An initial assessment, dated 6-22-21, indicated Resident E had a history of falls within the prior the 30 days, uses a cane or wheelchair for mobility and has "some long-term forgetfulness." Review of her current medication orders indicates she is physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident E's initial service plan, dated 6-22-21, did not reflect either concern related to being a high fall risk or the use of an anticoagulant. On 8-3-21 at 3:22 p.m., the Administrator provided a copy of a policy entitled, "Service Plans," and identified as reviewed most recently on 4/2016. This policy indicated, "Each resident will have a written plan of care that is		as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** August 26, 2021	

developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs...Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. Within seven days of completion of assessment tool (i.e., RAI) [Resident Assessment Instrument], all areas of concern will be addressed via the Service Plan...The nursing staff along with the resident and/or family members will identify resident problems, needs and strengths...All service plans are to reviewed every quarter and upon significant change in condition..."

This Residential tag relates to Complaint IN00359262.

2.5-2(a)

Based on interview and record review, the facility failed to ensure 3 of 4 residents reviewed for falls and anticoagulant use had evaluations reflect these issues. (Resident C, D and E)

Findings include:

1. The clinical record of Resident C was reviewed on 8-2-21 at 12:16 p.m. His diagnoses included, but was not limited to, cerebrovascular

	disease, hypertension, diabetes with neuropathy, joint pain and unsteadiness on his feet. It indicated a fall risk assessment was conducted on 12-2-20, indicating he was at high risk for falls. A general assessment was conducted on 12-2-20, which indicated he uses a walker and has some cognitive issues when in new situations. The clinical record indicated an evaluation of the resident was conducted on 3-13-21. Review of the service plans, most recently updated on 8-11-20 and 12-18-20, failed to reflect any concerns with Resident C being a high fall risk. In an interview with a family member on 8-2-21 at 1:57 p.m., she indicated Resident C had a fall in his room on 7-27-21, resulting in a hospitalization. As of 8-2-21, he remained in the hospital. 2. The clinical record of Resident D was reviewed on 8-4-21 at 11:01 a.m. Her diagnoses included, but were not limited to morbid obesity and a history of substance dependency. A "SLUMS" (St. Louis University Mental Status exam for dementia) indicated she scored within the normal range on her preadmission evaluation, conducted 6-3-21. A fall risk assessment, conducted on 4-23-21, on a preadmission evaluation indicated she was a			

	high fall risk and that she had experienced falls in the last 6 months. Review of her medications indicated she was physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident D has had a minimum of 3 falls since she admitted to the facility on 6-5-21. Review of her initial service plan, dated 6-4-21, did not reflect either concern related to being a high fall risk or the use of an anticoagulant. 3. The clinical record of Resident E was reviewed on 8-4-21 at 11:45 a.m. Her diagnoses included, but were not limited to, intracardiac thrombosis (blood clot in the heart), hypertension, peripheral vascular disease, coronary artery disease and Hepatitis C. An initial assessment, dated 6-22-21, indicated Resident E had a history of falls within the prior the 30 days, uses a cane or wheelchair for mobility and has "some long-term forgetfulness." Review of her current medication orders indicates she is physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident E's initial service plan, dated 6-22-21, did not reflect either concern related to being a high fall risk or the use of an			

	anticoagulant. On 8-3-21 at 3:22 p.m., the Administrator provided a copy of a policy entitled, "Service Plans," and identified as reviewed most recently on 4/2016. This policy indicated, "Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs...Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. Within seven days of completion of assessment tool (i.e., RAI) [Resident Assessment Instrument], all areas of concern will be addressed via the Service Plan...The nursing staff along with the resident and/or family members will identify resident problems, needs and strengths...All service plans are to reviewed every quarter and upon significant change in condition..." This Residential tag relates to Complaint IN00359262. 2.5-2(a)			
R 0217	Evaluation - Deficiency 410 IAC 16.2-5-2(e)(1-5)	R 0217	-**What corrective action(s) will be accomplished for those**	08/26/2021

	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and		**residents found to have been affected by the deficient practice?** Resident C discharged from community on 8/01/2021. Resident D service plan was reviewed by DON and updated to reflect high fall risk and the use of anticoagulants. Resident E service plan was reviewed by DON and updated to reflect high fall risk and the use of anticoagulants. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All other residents had the potential to be affected by this deficient practice. Service plans were audited on 8/6/2021 by the DON and then updated as needed to ensure that every resident's service plan reflects	

	documentation of the services to be provided. Based on interview and record review, the facility failed to ensure 3 of 4 residents reviewed for falls and anticoagulant use had service plans reflect these care issues. (Resident C, D and E) Findings include: 1. The clinical record of Resident C was reviewed on 8-2-21 at 12:16 p.m. His diagnoses included, but was not limited to, cerebrovascular disease, hypertension, diabetes with neuropathy, joint pain and unsteadiness on his feet. It indicated a fall risk assessment was conducted on 12-2-20, indicating he was at high risk for falls. A general assessment was conducted on 12-2-20, which indicated he uses a walker and has some cognitive issues when in new situations. The clinical record indicated an evaluation of the resident was conducted on 3-13-21. Review of the service plans, most recently updated on 8-11-20 and 12-18-20, failed to reflect any concerns with Resident C being a high fall risk. In an interview with a family member on 8-2-21 at 1:57 p.m., she indicated Resident C had a fall in his room on 7-27-21, resulting in a hospitalization. As		their plan of care. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** DON educated nursing staff on 8/6/2021 on the importance ensuring all service plans reflect the residents plan of care and to ensure the service plans get updated as needed. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed.	

	of 8-2-21, he remained in the hospital. 2. The clinical record of Resident D was reviewed on 8-4-21 at 11:01 a.m. Her diagnoses included, but were not limited to morbid obesity and a history of substance dependency. A "SLUMS" (St. Louis University Mental Status exam for dementia) indicated she scored within the normal range on her preadmission evaluation, conducted 6-3-21. A fall risk assessment, conducted on 4-23-21, on a preadmission evaluation indicated she was a high fall risk and that she had experienced falls in the last 6 months. Review of her medications indicated she was physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident D has had a minimum of 3 falls since she admitted to the facility on 6-5-21. Review of her initial service plan, dated 6-4-21, did not reflect either concern related to being a high fall risk or the use of an anticoagulant. 3. The clinical record of Resident E was reviewed on 8-4-21 at 11:45 a.m. Her diagnoses included, but were not limited to, intracardiac thrombosis (blood clot in the heart), hypertension, peripheral vascular disease, coronary		At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** August 26, 2021	

	artery disease and Hepatitis C. An initial assessment, dated 6-22-21, indicated Resident E had a history of falls within the prior the 30 days, uses a cane or wheelchair for mobility and has "some long-term forgetfulness." Review of her current medication orders indicates she is physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident E's initial service plan, dated 6-22-21, did not reflect either concern related to being a high fall risk or the use of an anticoagulant. On 8-3-21 at 3:22 p.m., the Administrator provided a copy of a policy entitled, "Service Plans," and identified as reviewed most recently on 4/2016. This policy indicated, "Each resident will have a written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs...Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. Within seven days of completion of assessment tool (i.e., RAI) [Resident Assessment Instrument], all areas of concern will be addressed via the Service			

	Plan...The nursing staff along with the resident and/or family members will identify resident problems, needs and strengths...All service plans are to reviewed every quarter and upon significant change in condition..." This Residential tag relates to Complaint IN00359262. 2.5-2(e)(1)(A) 2.5-2(e)(1)(B) 2.5-2(e)(1)(C) 2.5-2(e)(2) Based on interview and record review, the facility failed to ensure 3 of 4 residents reviewed for falls and anticoagulant use had service plans reflect these care issues. (Resident C, D and E) Findings include: 1. The clinical record of Resident C was reviewed on 8-2-21 at 12:16 p.m. His diagnoses included, but was not limited to, cerebrovascular disease, hypertension, diabetes with neuropathy, joint pain and unsteadiness on his feet. It indicated a fall risk assessment was conducted on 12-2-20, indicating he was at high risk for falls. A general assessment was conducted on 12-2-20, which indicated he uses a walker and			

	has some cognitive issues when in new situations. The clinical record indicated an evaluation of the resident was conducted on 3-13-21. Review of the service plans, most recently updated on 8-11-20 and 12-18-20, failed to reflect any concerns with Resident C being a high fall risk. In an interview with a family member on 8-2-21 at 1:57 p.m., she indicated Resident C had a fall in his room on 7-27-21, resulting in a hospitalization. As of 8-2-21, he remained in the hospital. 2. The clinical record of Resident D was reviewed on 8-4-21 at 11:01 a.m. Her diagnoses included, but were not limited to morbid obesity and a history of substance dependency. A "SLUMS" (St. Louis University Mental Status exam for dementia) indicated she scored within the normal range on her preadmission evaluation, conducted 6-3-21. A fall risk assessment, conducted on 4-23-21, on a preadmission evaluation indicated she was a high fall risk and that she had experienced falls in the last 6 months. Review of her medications indicated she was physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident D has had a minimum			

	of 3 falls since she admitted to the facility on 6-5-21. Review of her initial service plan, dated 6-4-21, did not reflect either concern related to being a high fall risk or the use of an anticoagulant. 3. The clinical record of Resident E was reviewed on 8-4-21 at 11:45 a.m. Her diagnoses included, but were not limited to, intracardiac thrombosis (blood clot in the heart), hypertension, peripheral vascular disease, coronary artery disease and Hepatitis C. An initial assessment, dated 6-22-21, indicated Resident E had a history of falls within the prior the 30 days, uses a cane or wheelchair for mobility and has "some long-term forgetfulness." Review of her current medication orders indicates she is physician ordered to receive Eliquis, an anticoagulant (blood thinner) twice daily. Review of the clinical record indicated Resident E's initial service plan, dated 6-22-21, did not reflect either concern related to being a high fall risk or the use of an anticoagulant. On 8-3-21 at 3:22 p.m., the Administrator provided a copy of a policy entitled, "Service Plans," and identified as reviewed most recently on 4/2016. This policy indicated, "Each resident will have a			

	written plan of care that is developed based on initial assessment, annual comprehensive assessment, quarterly evaluations, and changes in resident needs...Within 24 hours of admission, an Initial Service Plan will be completed that identifies potential immediate problems. Within seven days of completion of assessment tool (i.e., RAI) [Resident Assessment Instrument], all areas of concern will be addressed via the Service Plan...The nursing staff along with the resident and/or family members will identify resident problems, needs and strengths...All service plans are to reviewed every quarter and upon significant change in condition..." This Residential tag relates to Complaint IN00359262. 2.5-2(e)(1)(A) 2.5-2(e)(1)(B) 2.5-2(e)(1)(C) 2.5-2(e)(2)			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and	R 0295	R295 **What corrective action(s) will be accomplished for those**	08/26/2021

	nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, the facility failed to ensure 2 of 5 residents who were facility-identified as assessed to not self-administer medications, had medications unsecured in their rooms. (Residents C and F) Findings include: 1. In an observation of the locked medication cabinet and an unlocked refrigerator in the room of Resident C with the Director of Nursing (DON) on 8-2-21 at 3:34 p.m., the resident's insulin was located in the refrigerator. The insulin located in the refrigerator was as follows: -3 pens of Novolog located lying loose in a clear container, unlabeled without the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Its expiration date was listed as 6/2023. -1 labeled box of 4 pens of Novolog, with an expiration date of 12/2022. -1 labeled box of 5 pens of Novolog, with an expiration date of 1/2023. -1 labeled box of 3 pens of		**residents found to have been affected by the deficient practice?** Resident C discharged from community on 8/01/2021. Resident F medications were immediate taken to the nurse station and locked up in the medication room. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** An audit was completed on August 6, 2021 by the DON/Designee to identify other residents that could have been affected by this deficient practice. Licensed nurses educated by DON on August 6, 2021 for completion and accuracy on medication administration and medication storage for all residents. -**What measures will**	

	Novolog, with an expiration date of 6/2023. -1 pen of Basaglar located lying loose in a clear container, unlabeled without the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Its expiration date was listed as 1/2022. -1 labeled box of 5 pens of Basaglar, with an expiration date of 11/2020. -1 labeled box of 4 pens of Basaglar, with an expiration date of 6/2022. Review of Resident C's current medication orders indicated he is to receive Novolog insulin flexpen 4 units SQ (subcutaneously or under the skin) 3 times daily and Basaglar Kwikpen insulin 8 units SQ at bedtime each evening. 2. During an observation of a medication pass on 8-4-21 at 8:57 a.m., with QMA 2, several medications were observed sitting in front of the resident's television and not secured in her locked medication cabinet in her room. Those medications were as follows: -1 Albuterol HFA 90 mcg (micrograms) inhaler, without labeling to indicate the resident's name, physician's name, prescription number,		**be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** All medications will be stored in the medication room for those residents who we administer medications too. They will be labeled and dated as required per policy, procedure, and guidelines. This plan will be reviewed by the DON/Designee to ensure that they are correct and reflect the residents Service Plan and are being followed within the daily CQI. Any concerns will be addressed and corrected as observed. These audits will continue until 4 consecutive weeks of zero negative findings are achieved. After that, audits will take place weekly for these residents for a period of not less than 6 months to ensure ongoing compliance. After that, random audits will occur ongoing as part of the QAPI process. Any concerns will be addressed and corrected as observed.	

	directions for use, date of issue or pharmacy name. - 1 tube of Diclofen AC 1% gel in a box with the same information and appropriately labeled. - 1 bottle of generic Flonase 50 mcg, without labeling to indicate the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. -1 bottle of an OTC (over the counter) medication of Biofreeze. The bottle of Biofreeze had the manufacturer's label on it, but did not include labeling with the resident's name or the physician's name. Review of Resident F's current medication orders indicated she is to receive Flonase 50 mcg, 2 sprays into each nostril daily, Albuterol HFA 90 mcg 2 puffs every 6 hours as needed for for wheezing, Diclofen AC 1% gel, apply topically to bilateral knees every 12 hours as needed for knee pain. Review of Resident F's current medication orders did not include any orders for Biofreeze. QMA 2 was observed to explain to Resident F she would be taking those medications to the nurse on duty and she then was observed to take the medications to the nursing office		-**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** August 26, 2021	

	and place them in the Medication Room. In an interview at this time, she indicated when she finds any unsecured medications in a resident's room, she takes the medication to the nursing office and informs the nurse on duty of what occurred. In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all current state regulations. This Residential tag relates to Complaint IN00359262. 2.5-6(a) Based on observation, interview and record review, the facility failed to ensure 2 of 5 residents who were facility-identified as assessed to not self-administer medications, had medications unsecured in their rooms. (Residents C and F) Findings include:			

	1. In an observation of the locked medication cabinet and an unlocked refrigerator in the room of Resident C with the Director of Nursing (DON) on 8-2-21 at 3:34 p.m., the resident's insulin was located in the refrigerator. The insulin located in the refrigerator was as follows: -3 pens of Novolog located lying loose in a clear container, unlabeled without the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Its expiration date was listed as 6/2023. -1 labeled box of 4 pens of Novolog, with an expiration date of 12/2022. -1 labeled box of 5 pens of Novolog, with an expiration date of 1/2023. -1 labeled box of 3 pens of Novolog, with an expiration date of 6/2023. -1 pen of Basaglar located lying loose in a clear container, unlabeled without the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Its expiration date was listed as 1/2022.			

-1 labeled box of 5 pens of Basaglar, with an expiration date of 11/2020.

-1 labeled box of 4 pens of Basaglar, with an expiration date of 6/2022.

Review of Resident C's current medication orders indicated he is to receive Novolog insulin flexpen 4 units SQ (subcutaneously or under the skin) 3 times daily and Basaglar Kwikpen insulin 8 units SQ at bedtime each evening.

2. During an observation of a medication pass on 8-4-21 at 8:57 a.m., with QMA 2, several medications were observed sitting in front of the resident's television and not secured in her locked medication cabinet in her room. Those medications were as follows:

-1 Albuterol HFA 90 mcg (micrograms) inhaler, without labeling to indicate the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name.

- 1 tube of Diclofen AC 1% gel in a box with the same information and appropriately labeled.

- 1 bottle of generic Flonase 50 mcg, without labeling to indicate the resident's name, physician's name, prescription number,

directions for use, date of issue or pharmacy name.

-1 bottle of an OTC (over the counter) medication of Biofreeze. The bottle of Biofreeze had the manufacturer's label on it, but did not include labeling with the resident's name or the physician's name.

Review of Resident F's current medication orders indicated she is to receive Flonase 50 mcg, 2 sprays into each nostril daily, Albuterol HFA 90 mcg 2 puffs every 6 hours as needed for for wheezing, Diclofen AC 1% gel, apply topically to bilateral knees every 12 hours as needed for knee pain. Review of Resident F's current medication orders did not include any orders for Biofreeze.

QMA 2 was observed to explain to Resident F she would be taking those medications to the nurse on duty and she then was observed to take the medications to the nursing office and place them in the Medication Room. In an interview at this time, she indicated when she finds any unsecured medications in a resident's room, she takes the medication to the nursing office and informs the nurse on duty of what occurred.

In an interview with the DON on

	8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all current state regulations. This Residential tag relates to Complaint IN00359262. 2.5-6(a)			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on interview, the facility failed to ensure clearly written policies and procedures related to medication assistance were maintained. Findings include: In an interview with the DON on 8-4-21 at 3:12 p.m., she could not locate any particular facility policies regarding medications and medication management. She explained she had received several policies from the corporate office related to medications and medication management, but specific to another state. She indicated the	R 0296	R296 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No resident was affected by this deficient practice -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** An audit was completed on August 6, 2021 by the DON/Designee to identify other residents that could have been affected by this	08/26/2021

	facility's goal is to follow all current state regulations. This Residential tag relates to Complaint IN00359262. 2.5-6(b) Based on interview, the facility failed to ensure clearly written policies and procedures related to medication assistance were maintained. Findings include: In an interview with the DON on 8-4-21 at 3:12 p.m., she could not locate any particular facility policies regarding medications and medication management. She explained she had received several policies from the corporate office related to medications and medication management, but specific to another state. She indicated the facility's goal is to follow all current state regulations. This Residential tag relates to Complaint IN00359262. 2.5-6(b)		deficient practice. Licensed nurses educated by DON on August 6, 2021 for completion and accuracy on medication administration and medication storage for all residents. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Medication administration and storage policy was located and given to all nursing staff 8/6/2021 and reviewed with by DON. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.**	

			This policy will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** August 26, 2021	
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name.	R 0301	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident C discharged from	08/26/2021

	(B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, interview and record review, the facility failed to ensure all medications for 2 of 5 residents reviewed for medications are labeled with the appropriate information. (Resident C and F) Findings include: 1. In an observation of the locked medication cabinet and an unlocked refrigerator in the room of Resident C with the Director of Nursing (DON) on 8-2-21 at 3:34 p.m., the resident's insulin was located in the refrigerator. The insulin located in the refrigerator was as follows: -3 pens of Novolog located lying loose in a clear container, unlabeled without the resident's		community on 8/01/2021. Resident F medications were immediately taken to the nurse station and locked up in the medication room. Labeled, and dated according to policy and guidelines. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** An audit was completed on August 6, 2021 by the DON/Designee to identify other residents that could have been affected by this deficient practice. Licensed nurses educated by DON on August 6, 2021 for completion and accuracy on medication labeling for all residents. -**What measures will be put into place or what systemic changes will be**	

	name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Its expiration date was listed as 6/2023. -1 pen of Basaglar located lying loose in a clear container, unlabeled without the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Its expiration date was listed as 1/2022. Review of Resident C's current medication orders indicated he is to receive Novolog insulin flexpen 4 units SQ (subcutaneously or under the skin) 3 times daily and Basaglar Kwikpen insulin 8 units SQ at bedtime each evening. 2. During an observation of a medication pass on 8-4-21 at 8:57 a.m., with QMA 2, several medications were observed sitting in front of the resident's television and not secured in her locked medication cabinet in her room. Those medications were as follows: -1 Albuterol HFA 90 mcg (micrograms) inhaler, without labeling to indicate the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. - 1 tube of Diclofen AC 1% gel in a box with the same		**made to ensure that the deficient practice does not recur?** Medication administration, storage and labeling policy was located and given to all nursing staff 8/6/2021 and reviewed with by DON. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This policy will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any	

	information and appropriately labeled. - 1 bottle of generic Flonase 50 mcg, without labeling to indicate the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Review of Resident F's current medication orders indicated she is to receive Flonase 50 mcg, 2 sprays into each nostril daily, Albuterol HFA 90 mcg 2 puffs every 6 hours as needed for for wheezing, Diclofen AC 1% gel, apply topically to bilateral knees every 12 hours as needed for knee pain. QMA 2 was observed to explain to Resident F she would be taking those medications to the nurse on duty and she then was observed to take the medications to the nursing office and place them in the Medication Room. In an interview at this time, she indicated when she finds any unsecured medications in a resident's room, she takes the medication to the nursing office and informs the nurse on duty of what occurred. In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all		concerns will be addressed as discovered. -**By what date the systematic changes will be completed** August 26, 2021	

current state regulations.

This Residential tag relates to Complaint IN00359262.

2.5-6(c)(5)(A)

2.5-6(c)(5)(B)

2.5-6(c)(5)(C)

2.5-6(c)(5)(E)

2.5-6(c)(5)(F)

2.5-6(c)(5)(G)

Based on observation, interview and record review, the facility failed to ensure all medications for 2 of 5 residents reviewed for medications are labeled with the appropriate information. (Resident C and F)

Findings include:

1. In an observation of the locked medication cabinet and an unlocked refrigerator in the room of Resident C with the Director of Nursing (DON) on 8-2-21 at 3:34 p.m., the resident's insulin was located in the refrigerator. The insulin located in the refrigerator was as follows:

-3 pens of Novolog located lying loose in a clear container, unlabeled without the resident's name, physician's name, prescription number, directions for use, date of issue or

pharmacy name. Its expiration date was listed as 6/2023.

-1 pen of Basaglar located lying loose in a clear container, unlabeled without the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Its expiration date was listed as 1/2022.

Review of Resident C's current medication orders indicated he is to receive Novolog insulin flexpen 4 units SQ (subcutaneously or under the skin) 3 times daily and Basaglar Kwikpen insulin 8 units SQ at bedtime each evening.

2. During an observation of a medication pass on 8-4-21 at 8:57 a.m., with QMA 2, several medications were observed sitting in front of the resident's television and not secured in her locked medication cabinet in her room. Those medications were as follows:

-1 Albuterol HFA 90 mcg (micrograms) inhaler, without labeling to indicate the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name.

- 1 tube of Diclofen AC 1% gel in a box with the same information and appropriately labeled.

	- 1 bottle of generic Flonase 50 mcg, without labeling to indicate the resident's name, physician's name, prescription number, directions for use, date of issue or pharmacy name. Review of Resident F's current medication orders indicated she is to receive Flonase 50 mcg, 2 sprays into each nostril daily, Albuterol HFA 90 mcg 2 puffs every 6 hours as needed for for wheezing, Diclofen AC 1% gel, apply topically to bilateral knees every 12 hours as needed for knee pain. QMA 2 was observed to explain to Resident F she would be taking those medications to the nurse on duty and she then was observed to take the medications to the nursing office and place them in the Medication Room. In an interview at this time, she indicated when she finds any unsecured medications in a resident's room, she takes the medication to the nursing office and informs the nurse on duty of what occurred. In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all current state regulations. This Residential tag relates to			

	Complaint IN00359262. 2.5-6(c)(5)(A) 2.5-6(c)(5)(B) 2.5-6(c)(5)(C) 2.5-6(c)(5)(E) 2.5-6(c)(5)(F) 2.5-6(c)(5)(G)			
R 0302	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(6) (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview and record review, the facility failed to ensure all medications for 1 of 5 residents reviewed for medications are labeled with the appropriate information. (Resident F) Findings include: During an observation of a	R 0302	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident F medications were immediately taken to the nurse station and locked up in the medication room. Labeled, and dated according to policy and guidelines. -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** An audit was completed on August 6, 2021 by the DON/Designee to identify other	08/26/2021

	medication pass on 8-4-21 at 8:57 a.m., with QMA 2, several medications were observed sitting in front of the resident's television and not secured in her locked medication cabinet in her room. Those medications included several prescription medications and an OTC (over the counter) medication of Biofreeze. The bottle of Biofreeze had the manufacturer's label on it, but did not include labeling with the resident's name or the physician's name. Review of Resident F's current medication orders did not include any orders for Biofreeze. QMA 2 was observed to explain to Resident F she would be taking those medications to the nurse on duty and she then was observed to take the medications to the nursing office and place them in the Medication Room. In an interview at this time, she indicated when she finds any unsecured medications in a resident's room, she takes the medication to the nursing office and informs the nurse on duty of what occurred. In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all		residents that could have been affected by this deficient practice. Licensed nurses educated by DON on August 6, 2021 for completion and accuracy on medication labeling for all residents. -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Medication administration, storage and labeling policy was located and given to all nursing staff 8/6/2021 and reviewed with by DON. -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.**	

	current state regulations. This Residential tag relates to Complaint IN00359262. 2.5-6(c)(6)(A) 2.5-6(c)(6)(B) Based on observation, interview and record review, the facility failed to ensure all medications for 1 of 5 residents reviewed for medications are labeled with the appropriate information. (Resident F) Findings include: During an observation of a medication pass on 8-4-21 at 8:57 a.m., with QMA 2, several medications were observed sitting in front of the resident's television and not secured in her locked medication cabinet in her room. Those medications included several prescription medications and an OTC (over the counter) medication of Biofreeze. The bottle of Biofreeze had the manufacturer's label on it, but did not include labeling with the resident's name or the physician's name. Review of Resident F's current medication orders did not include any orders for Biofreeze. QMA 2 was observed to explain to Resident F she would be taking those medications to the		This policy will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** August 26, 2021	

	nurse on duty and she then was observed to take the medications to the nursing office and place them in the Medication Room. In an interview at this time, she indicated when she finds any unsecured medications in a resident's room, she takes the medication to the nursing office and informs the nurse on duty of what occurred. In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all current state regulations. This Residential tag relates to Complaint IN00359262. 2.5-6(c)(6)(A) 2.5-6(c)(6)(B)			

R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure the medication room, located inside the nursing office, was locked and secured at all times. Findings include: In random observations conducted on 8-2-21 and 8-4-21, the medication room door was observed to be unlocked and open, in addition to the nursing office door being unlocked and open, both when staff were present in the nursing office and when staff were absent from the nursing office. In an interview on 8-4-21 at 9:42 a.m., with QMA (qualified medication aide) 2, she indicated the medication room door is left unlocked "because we don't have the key for it." In an observation of the	R 0304	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No resident was affected by this deficient practice -**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** No resident had the potential to be affected by this deficient practice -**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** Medication administration, storage and labeling policy was located and given to all nursing staff 8/6/2021 and reviewed with by DON.	08/26/2021

	medication room on 8-4-21 at 9:42 a.m., with QMA 2, numerous medications were observed within the medication room. In an interview on 8-4-21 at 9:55 a.m., with the Director of Nursing (DON), indicated the facility does not lock the medication room as she is the only nurse with a master key that can open the door's lock to the medication room. She indicated she had discussed this issue with the Maintenance Director previously, but nothing has been done about it. She clarified any narcotic medications in the medication room are doubled locked as a security method. "We can lock the nursing office, but the med room would still be unlocked." In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all current state regulations. 2.5-6(e) Based on observation and interview, the facility failed to ensure the medication room, located inside the nursing office, was locked and secured at all times. Findings include:		-**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This policy will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered. -**By what date the systematic changes will be completed** August 26, 2021	

	In random observations conducted on 8-2-21 and 8-4-21, the medication room door was observed to be unlocked and open, in addition to the nursing office door being unlocked and open, both when staff were present in the nursing office and when staff were absent from the nursing office. In an interview on 8-4-21 at 9:42 a.m., with QMA (qualified medication aide) 2, she indicated the medication room door is left unlocked "because we don't have the key for it." In an observation of the medication room on 8-4-21 at 9:42 a.m., with QMA 2, numerous medications were observed within the medication room.			

	In an interview on 8-4-21 at 9:55 a.m., with the Director of Nursing (DON), indicated the facility does not lock the medication room as she is the only nurse with a master key that can open the door's lock to the medication room. She indicated she had discussed this issue with the Maintenance Director previously, but nothing has been done about it. She clarified any narcotic medications in the medication room are doubled locked as a security method. "We can lock the nursing office, but the med room would still be unlocked." In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated she could not locate any particular facility policies regarding this topic, but the facility's goal is to follow all current state regulations. 2.5-6(e)			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete.	R 0349	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B clinical record was reviewed as well as service plan and updated to reflect residents plan of care.	08/26/2021

(2) Accurately documented.

(3) Readily accessible.

(4) Systematically organized.

Based on interview and record review, the facility failed to ensure the clinical record for 3 of 4 residents reviewed for clinical records were complete and accurate to reflect any falls a resident had were documented and any actions taken by the facility post fall were documented and the physician-ordered medications were administered as ordered. (Residents B, C and D)

Findings include:

1. The clinical record or Resident B was reviewed on 8-2-21 at 11:39 p.m. Her diagnoses included, but were not limited to chronic atrial fibrillation, unspecific protein-calorie malnutrition, hypertension, general muscle weakness and chronic pulmonary obstructive disease (COPD).

Resident C discharged from community on 8/01/2021.

Resident D clinical record was reviewed as well as service plan and updated to reflect residents plan of care.

-**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.**

An audit was completed on August 6, 2021 by the DON/Designee to identify other residents that could have been affected by this deficient practice.

Licensed nurses educated by DON on August 6, 2021 for completion and accuracy on documentation in the clinical record for all residents.

-**What measures will be put into place or what systemic changes will be made to ensure that the deficient**

	On 8-3-21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of the facility's July, 2021 fall log. Resident B was identified on the fall log as having a fall on 7-27-21 and 7-28-21, with both falls identified as "unwitnessed," without injury and the resident was not sent out to the hospital. In review of the progress notes for Resident B, the fall on 7-27-21 was documented as occurring on the morning of that date and she was found lying on the floor of her apartment after she had slid to the floor while trying to use her walker. It indicated the resident was assessed for injuries and none were identified and she did not complain of pain. The next and final entry of the progress notes indicated on 7-27-21 at 9:55 p.m., the resident continued to be on follow-up for a fall with no injuries or complaints of pain. There were no entries related to a fall, as reported on the fall log, of a fall for Resident B on 7-27-21. In an interview with the DON on 8-4-21 at 2:00 p.m., she indicated the 7-27-21 fall was documented on an incident report form, but lacked a progress note in the clinical regarding the fall. She indicated as it is an internal document, she could not share the report. She indicated she was in		**practice does not recur?** DON/Designee will review all fall notes to ensure that accurate documentation and corrective actions were in place and noted in the residents clinical chart -**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.** This process will be reviewed by DON/designee, IDT Team, and Administrator weekly for 8 weeks, monthly for 4 months and then as needed. At the monthly QA meetings, the results of the monitoring will be reviewed. Any patterns will be identified. If indicated, an Action Plan will be written by the QA Committee. Any Action Plan will be reviewed weekly by the Administrator until resolved. Any concerns will be addressed as discovered.	

	contact with the family of Resident B after the 7-27-21 fall and a decision was made by the family to send her to the hospital, related to two falls within two days and complaints of minor hip pain. She indicated Resident B remained at the hospital as of the time of the interview and will be re-evaluated prior to re-admission to the facility. 2. The clinical record of Resident C was reviewed on 8-2-21 at 12:16 p.m. His diagnoses included, but was not limited to, cerebrovascular disease, hypertension, diabetes with neuropathy, joint pain and unsteadiness on his feet. Resident C's current physician orders for his insulin include, but are not limited to, Basaglar Kwikpen 8 units SQ (subcutaneously or under the skin) at bedtime and Novolog Flexpen 4 units SQ 3 times daily. An associated order for blood glucose monitoring are to be conducted before meals and at bedtime, with orders to notify the physician for blood glucose reading below 100 or above 300. In review of Resident C's electronic medication administration record (EMAR), specific to his insulin and associated blood glucose monitoring, a lack of		-**By what date the systematic changes will be completed** August 26, 2021	

documentation of administration of the Basaglar insulin was present on 7-5-21, 7-9-21 and 7-11-21. A lack of documentation of administration of the Novolog insulin was present on 7-5-21 at 4:00 p.m., 7-11-21 at 12:00 p.m. and 4:00 p.m., 7-12-21 at 4:00 p.m., and 7-25-21 at 12:00 p.m. A lack of documentation of results of blood glucose results was present on 7-1-21 at 8:00 p.m., 7-3-21 at 8:00 p.m., 7-4-21 at 12:00 p.m., 7-5-21 at 4:00 p.m. and 8:00 p.m., 7-9-21 at 8:00 p.m., 7-11-21 at 4:00 p.m. and 8:00 p.m., 7-20-21 at 8:00 p.m., and 7-25-21 at 12:00 p.m.

3. The clinical record of Resident D was reviewed on 8-4-21 at 11:01 a.m. Her diagnoses included, but were not limited to morbid obesity and a history of substance dependency.

On 8-3-21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of the facility's July, 2021 fall log. The fall log indicated Resident D had an unwitnessed fall on 7-3-21 in which she experienced no injuries and was not sent to the hospital.

Review of Resident D's progress notes indicated she had documented unwitnessed falls on 6-5-21 and 6-10-21 in which she experienced no

injuries and was not sent to the hospital. The most recent progress note entry, dated 7-3-21, indicated she remained on follow-up for a fall with no complaints of pain and no apparent injuries.

In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated the 7-3-21 fall was documented on an incident report form, but as it is an internal document, she could not share the report, but lacked a progress note in the clinical record regarding the fall.

In an interview with the DON on 8-2-21 at 4:42 p.m., she indicated her expectations for documentation are that "anything significant should be documented and that includes for the licensed nurses to document their assessments and and care issues like falls or change in condition. For the QMA's, they cannot document assessments, but they can document statements of fact, such as why a resident went to the hospital, observations of a fall or who they notified about things or what a resident said."

This Residential tag relates to Complaint IN00359262.

2.5-8.1(a)(1)

2.5-8.1(a)(2)

Based on interview and record

review, the facility failed to ensure the clinical record for 3 of 4 residents reviewed for clinical records were complete and accurate to reflect any falls a resident had were documented and any actions taken by the facility post fall were documented and the physician-ordered medications were administered as ordered. (Residents B, C and D)

Findings include:

1. The clinical record or Resident B was reviewed on 8-2-21 at 11:39 p.m. Her diagnoses included, but were not limited to chronic atrial fibrillation, unspecific protein-calorie malnutrition, hypertension, general muscle weakness and chronic pulmonary obstructive disease (COPD).

On 8-3-21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of the facility's July, 2021 fall log. Resident B was identified on the fall log as having a fall on 7-27-21 and 7-28-21, with both falls identified as "unwitnessed," without injury and the resident was not sent out to the hospital.

In review of the progress notes for Resident B, the fall on 7-27-21 was documented as occurring on the morning of that date and she was found lying on

the floor of her apartment after she had slid to the floor while trying to use her walker. It indicated the resident was assessed for injuries and none were identified and she did not complain of pain.

The next and final entry of the progress notes indicated on 7-27-21 at 9:55 p.m., the resident continued to be on follow-up for a fall with no injuries or complaints of pain. There were no entries related to a fall, as reported on the fall log, of a fall for Resident B on 7-27-21. In an interview with the DON on 8-4-21 at 2:00 p.m., she indicated the 7-27-21 fall was documented on an incident report form, but lacked a progress note in the clinical regarding the fall. She indicated as it is an internal document, she could not share the report. She indicated she was in contact with the family of Resident B after the 7-27-21 fall and a decision was made by the family to send her to the hospital, related to two falls within two days and complaints of minor hip pain. She indicated Resident B remained at the hospital as of the time of the interview and will be re-evaluated prior to re-admission to the facility.

2. The clinical record of Resident C was reviewed on 8-2-21 at 12:16 p.m. His

diagnoses included, but was not limited to, cerebrovascular disease, hypertension, diabetes with neuropathy, joint pain and unsteadiness on his feet.

Resident C's current physician orders for his insulin include, but are not limited to, Basaglar Kwikpen 8 units SQ (subcutaneously or under the skin) at bedtime and Novolog Flexpen 4 units SQ 3 times daily. An associated order for blood glucose monitoring are to be conducted before meals and at bedtime, with orders to notify the physician for blood glucose reading below 100 or above 300.

In review of Resident C's electronic medication administration record (EMAR), specific to his insulin and associated blood glucose monitoring, a lack of documentation of administration of the Basaglar insulin was present on 7-5-21, 7-9-21 and 7-11-21. A lack of documentation of administration of the Novolog insulin was present on 7-5-21 at 4:00 p.m., 7-11-21 at 12:00 p.m. and 4:00 p.m., 7-12-21 at 4:00 p.m., and 7-25-21 at 12:00 p.m. A lack of documentation of results of blood glucose results was present on 7-1-21 at 8:00 p.m., 7-3-21 at 8:00 p.m., 7-4-21 at 12:00 p.m., 7-5-21 at 4:00 p.m. and 8:00 p.m., 7-9-21 at 8:00

p.m., 7-11-21 at 4:00 p.m. and 8:00 p.m., 7-20-21 at 8:00 p.m., and 7-25-21 at 12:00 p.m.

3. The clinical record of Resident D was reviewed on 8-4-21 at 11:01 a.m. Her diagnoses included, but were not limited to morbid obesity and a history of substance dependency.

On 8-3-21 at 1:50 p.m., the Director of Nursing (DON) provided a copy of the facility's July, 2021 fall log. The fall log indicated Resident D had an unwitnessed fall on 7-3-21 in which she experienced no injuries and was not sent to the hospital.

Review of Resident D's progress notes indicated she had documented unwitnessed falls on 6-5-21 and 6-10-21 in which she experienced no injuries and was not sent to the hospital. The most recent progress note entry, dated 7-3-21, indicated she remained on follow-up for a fall with no complaints of pain and no apparent injuries.

In an interview with the DON on 8-4-21 at 3:12 p.m., she indicated the 7-3-21 fall was documented on an incident report form, but as it is an internal document, she could not share the report, but lacked a progress note in the clinical

	record regarding the fall. In an interview with the DON on 8-2-21 at 4:42 p.m., she indicated her expectations for documentation are that "anything significant should be documented and that includes for the licensed nurses to document their assessments and and care issues like falls or change in condition. For the QMA's, they cannot document assessments, but they can document statements of fact, such as why a resident went to the hospital, observations of a fall or who they notified about things or what a resident said." This Residential tag relates to Complaint IN00359262. 2.5-8.1(a)(1) 2.5-8.1(a)(2)			

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