STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER CREEK VILLAGE	990 PROGRESS PARKWAY, SHELBYVILLE, , 46176

(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 IN00360152 and Complaint IN00360290. Complaint IN00360152 - Substantiated. State deficiencies related to the allegations are cited at R0144 and R0247. Complaint IN00360290 - Substantiated. State deficiencies related to the allegations are cited at R0246, R0247, R0349, and R0357. Unrelated deficiencies cited. Survey dates: August 18, 19, and 20, 2021 Facility number: 014548 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on	R 0000		

	August 26, 2021			
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (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, the facility failed to immediately suspend a staff member after an allegation of verbal abuse which left Resident H fearful of retaliation. This affected 2 of 9 residents and had the potential to affect all 27 residents in the facility. (Residents B and H) Findings include: During an interview, on 8/19/21 at 11:38 a.m., Resident B indicated the Director of Nurses (DoN) has yelled at residents in the facility. Resident B indicated two residents who had told her the DoN yelled at them. On 8/19/21 at 3:40 p.m., the Administrator was notified of the	R 0052	R052: Upon receipt of an allegation of verbal abuse, the facility failed to suspend Director of Nursing (DON), after an allegation of verbal abuse, which left Resident H fearful of retaliation. This affected both residents B and H and had the potential to affect all 27 residents. 1. DON returned to work on 8/20/2021 and voluntarily resigned at 10:50am, with no intent to return. The part-time facility nurse assumed the DON responsibilities temporarily following the former DON resignation and a new Director of Nursing was hired and began employment with the facility on Thursday, September 2nd. 2. The facility will continue to provide a copy of Resident Rights to all residents upon admission and continue to have a copy publicly available in the facility library, for resident review. A copy is currently available in the facility library. 3. Facility staff will be retrained on	09/27/2021

	allegation of verbal abuse concerning the Director of Nursing. He indicated he would start the investigation and that he has not been made aware of this since he has been the Administrator and he started in June. On 8/20/21 at 10:30 a.m., Resident H indicated she has had issues with the DoN. She said the DoN is rude to her, about 2 weeks ago the DoN came into her room and was yelling about a medication error and was slamming her hands and some medication cards down on her countertop. Resident H said she was confused and fearful because the staff had been managing her medications at this time. She said she didn't report this to anyone because she was scared and didn't want to ruffle any feathers, and this has made her depressed and fearful when she was supposed to be in a safe place. During a confidential interview, a resident indicated about 2 weeks ago the DoN was yelling at a staff member and when she looked out of her room, the DoN yelled at her to go back to her room. She said this was reported to the Administrator but there was no follow through. She said she was afraid of the DoN coming into her room and yelling at her, and another staff		incidents, and the reporting of (to include abuse). Training to include proper documentation and the timely reporting of. When Administration receives an allegation of verbal abuse, the facility Administration will: a. Immediately suspend the employee; b. Report the allegation to the Indiana Department of Long-Term Care Long Term Care Division, via the web-based incident reporting system, and APS if applicable (Medicaid Resident); c. Investigate and write an investigation report, listing if substantiated, or not substantiated. If substantiated, the plan for correction. d. Reports the findings to the resident reporting the allegation. Facility staff to be retrained on neglect and abuse, by corporate Administration. 4. The facility corporate	

	member told her not to worry that if she did come in her room to yell at her for her to call 911. She said she was afraid they would retaliate against her. On 8/20/21 at 10:25 a.m., the Administrator was interviewed after the DoN was observed in the facility. When queried what the protocol is to investigate an allegation of abuse, he indicated that first he would do a resident interview. He said there is usually an incident report, then a resident interview, and he would contact corporate. He said it wasn't necessary to suspend the person during the investigation. The Administrator reviewed the facility's abuse and neglect policy and said he would take care of it. On 8/20/21 at 10:50 a.m., the DoN left the facility. A policy and procedure for "Abuse and Neglect" was provided by the Administrator on 8/19/21 at 12:55 p.m. The policy included but was not limited to: "Any facility employee or agent who has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the facility shall...2. The facility must suspend from duty and staff suspected, alleged, or involved in incidents of abuse, neglect, or exploitation pending investigation of the incident.		management team will monitor abuse allegations, distribution and location of a copy of Resident Rights, and the proper reporting and investigations of incidents. This monitoring will be quarterly, for one year, and then, annually forward. Corporate Administration will monitor training/in-service documentation, to include, but not limited to annual training on abuse and neglect and reporting incidents and accidents. This monitoring will be annually. 5. The facility Administration will monitor the distribution of Resident Rights upon move in, and the placement of a copy accessible to residents. This monitoring will be quarterly for one year, and then, annually, forward. 6. R052 Systemic changes to be complete by 9/27/2021.	

	After investigating facility must develop a written report within 14 days after the initial report. The facility shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report...All residents have the right to live in a home environment that treats them with dignity, respect and is free from any form of abuse or neglect at all times, and in all circumstances...Definition of Abuse and Neglect: This policy uses the definitions of "abuse" and "neglect". These definitions are as follows: "Abuse" in relation to a resident, means physical, sexual, emotional, verbal or financial abuse. "Neglect" means the failure to provide a resident with the treatment, care, services or assistance required for health, safely or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents...."			

	Based on interview and record review, the facility failed to immediately suspend a staff member after an allegation of verbal abuse which left Resident H fearful of retaliation. This affected 2 of 9 residents and had the potential to affect all 27 residents in the facility. (Residents B and H) Findings include: During an interview, on 8/19/21 at 11:38 a.m., Resident B indicated the Director of Nurses (DoN) has yelled at residents in the facility. Resident B indicated two residents who had told her the DoN yelled at them. On 8/19/21 at 3:40 p.m., the Administrator was notified of the allegation of verbal abuse concerning the Director of Nursing. He indicated he would start the investigation and that he has not been made aware of this since he has been the Administrator and he started in June. On 8/20/21 at 10:30 a.m., Resident H indicated she has had issues with the DoN. She said the DoN is rude to her, about 2 weeks ago the DoN came into her room and was yelling about a medication error and was slamming her hands and some medication cards down on her countertop. Resident H said she was			

	confused and fearful because the staff had been managing her medications at this time. She said she didn't report this to anyone because she was scared and didn't want to ruffle any feathers, and this has made her depressed and fearful when she was supposed to be in a safe place. During a confidential interview, a resident indicated about 2 weeks ago the DoN was yelling at a staff member and when she looked out of her room, the DoN yelled at her to go back to her room. She said this was reported to the Administrator but there was no follow through. She said she was afraid of the DoN coming into her room and yelling at her, and another staff member told her not to worry that if she did come in her room to yell at her for her to call 911. She said she was afraid they would retaliate against her. On 8/20/21 at 10:25 a.m., the Administrator was interviewed after the DoN was observed in the facility. When queried what the protocol is to investigate an allegation of abuse, he indicated that first he would do a resident interview. He said there is usually an incident report, then a resident interview, and he would contact corporate. He said it wasn't necessary to suspend the person during the investigation. The Administrator			

	reviewed the facility's abuse and neglect policy and said he would take care of it. On 8/20/21 at 10:50 a.m., the DoN left the facility. A policy and procedure for "Abuse and Neglect" was provided by the Administrator on 8/19/21 at 12:55 p.m. The policy included but was not limited to: "Any facility employee or agent who has a reasonable belief that a resident has been the victim of abuse, neglect, or financial exploitation, the facility shall...2. The facility must suspend from duty and staff suspected, alleged, or involved in incidents of abuse, neglect, or exploitation pending investigation of the incident. After investigating facility must develop a written report within 14 days after the initial report. The facility shall send the written report to the Department within 24 hours after it is completed and shall maintain a copy of the written report on the premises for 12 months after the date of the report...All residents have the right to live in a home environment that treats them with dignity, respect and is free from any form of abuse or neglect at all times, and in all circumstances...Definition of Abuse and Neglect: This policy uses the definitions of "abuse" and "neglect". These definitions are as follows: "Abuse" in			

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R 0144	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(a) (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation, interview, and record review, the facility failed to ensure resident rooms and common areas were clean and in good repair, failed to provide housekeeping and maintenance services for 6 of 6 residents reviewed, and had the potential to affect all 27 residents in the facility. (Residents M, L, D, G, H, and N) Findings include: During the initial tour on 8/18/21 at 11:00 a.m., an odor that was unrecognizable was observed in	R 0144	R144: The facility failed to ensure resident rooms and common areas were clean and in good repair and failed to provide housekeeping and maintenance services to residents M, L, D, G, H and N, with the potential to affect all 27 residents in the facility.	09/27/2021

	the hallway where rooms 1 through 12 are located, and the hallway where rooms 31 through 40 are located. This odor was present all 3 days of the survey. On 8/18/21 at 10:30 a.m., Resident M indicated their apartment has not been cleaned in 4 weeks and they have been trying to clean up after themselves. Resident M said it is in their service agreement to have housekeeping and they aren't receiving that service. On 8/18/21 at 11:10 a.m., Resident L indicated they are supposed to have someone come in to help with housekeeping, and they haven't had housekeeping for 5 or 6 weeks. They also have no maintenance and they have had to change their own light bulbs. On 8/18/21 at 1:10 p.m., Resident D's apartment was observed to have these problems: - The carpet in the living room had debris scattered all over it. Resident D indicated he hasn't had his apartment cleaned in 6 weeks. - The screen door in the living room, that opened to the patio, wouldn't slide into place so the door to the outside could be left open. The bottom of the screen was loose, and the rubber seals		1. A housekeeper and maintenance person have been hired for housekeeping and maintenance needs. Each new hire had been trained on the job description of their position, and each is working to bring the apartments, common areas, and facility in whole, up to standard (to include the apartments of residents M, L, D, G, H and N). Other employees are and will continue working on housekeeping and maintenance tasks during their down-time, also. Facility and Corporate Administration will continue to monitor staffing needs and hire accordingly. 2. Facility and Corporate Administration inspected all apartments of the facility, to include M, L, D, G and N, that were affected. And, all other resident apartments, to include 27 total. Facility and Corporate Administration hired new personnel for housekeeping and maintenance tasks and completed a cleaning schedule to bring all substandard cleaning to compliance. Facility Administration will	

	that held the screen in place on the door were hanging down on both sides of the door frame. - The commode had a large area of dried feces above the water line. The toilet seat was loose on the toilet. Resident D said he has slid off the toilet onto the floor and he just puts it back together when it comes apart. He said he doesn't tell staff when he falls. There is an odor in his bathroom because he can't clean it, and said they brought him a can of Febreze to cover it up. - Light bulbs were out in the kitchen and in the overhead bedroom light. Resident D said there is a sewer odor in the hallway that has been there for several months. It will get better but it doesn't completely go away. They are told it has something to do with empty apartments. On 8/18/21 at 1:20 p.m., Resident G indicated there was a lack of housekeeping and she was unsure how long it has been since the facility cleaned her room, but it was between 4 and 6 weeks ago. She said her daughter came by and deep cleaned about 2 weeks ago. Her daughter had told her that her apartment needed cleaned, and it is very dirty, and she was embarrassed. She said she has		continue to monitor resident apartments and common areas to make sure that housekeeping and maintenance tasks are completed correctly, and timely. 3. Facility and Corporate Administration reviewed job descriptions and weekly checklists of all positions, to include housekeeping and maintenance positions, and made changes to prevent this deficiency in the absence of a housekeeper or maintenance person, forward. Facility and Corporate Administration will retrain all staff on the job descriptions and checklists of their position. All maintenance needs that are beyond the capability of the facility staff, will be contracted out to a respective contractor for repaid and/or resolution. Facility and Corporate Administration will continue to monitor hiring needs of housekeeping and maintenance positions. 4. Completed daily, employee and housekeeping checklists and maintenances orders will be kept in a binder	

	always kept a tidy house and was upset her apartment got so untidy. She said her family has been doing her laundry since they do not have any staff; they don't have housekeeping staff, laundry staff, and they are without a maintenance man. On 8/18/21 at 1:40 p.m., Resident Assistant 5 indicated the facility currently doesn't have a Maintenance person or a housekeeper and said they do what they can to keep up. On 8/19/21 at 1:15 p.m., Resident O said there was an odor in the facility that has been here awhile. On 8/20/21 at 10:30 a.m., Resident H indicated her apartment has not been cleaned once since she moved in. (Resident moved into facility in April 2021) On 8/20/21 at 11:20 a.m., Resident N indicated she has had some issues with maintenance in the apartment, but nothing major and her daughter would be in soon to complete those if the facility doesn't complete those, including replacing her curtain rods. On 8/20/21 at 1:55 p.m., the Administrator indicated they had fixed the broken toilet once, they had replaced the toilet seat. He said because there is		for documentation of compliance with the facility housekeeping and maintenance policies. Facility Administration will monitor the completion of each checklist. Facility Administration will also monitor the facility apartments and common areas for proper and timely cleaning and maintenance. 5. Facility Administration will monitor weekly, for 1 month, and then, monthly forward and on going. 6. R144 Plan of Correction to be complete by 9/27/2021.	

	no Maintenance person right now, it's "all hands-on deck" to work together to get things done. An "Assisted Living Establishment Contract" was provided to each resident upon admission and is signed by the resident and a Management Representative. The contract included but wasn't limited to: "...5. FEES AND SERVICES PROVIDED - The base monthly fee for a resident is calculated by the size of apartment rented and level of care required...Services included for all residents, regardless of monthly fee include: (A) Weekly cleaning of the unit. (B) Weekly changing of bed and bath linens and personal laundry...." A "Resident Housekeeping and Laundry" policy and procedure was provided by Corporate Operations 6 and included but was not limited to: "Procedure: Housekeeping: Residents will have their living units cleaned weekly, unless otherwise requested by a resident. Housekeeping staff is responsible for the weekly cleaning of units. A schedule will be maintained so that specified units are done on the same day each week. Resident will be made aware of what day their apartment will be cleaned...The day an apartment is cleaned is the same day the housekeeper			

	will collect the linens and personal laundry from the apartment. New linens will be put on the bed when the apartment is cleaned...." A policy and procedure for "Maintenance" was provided by the Administrator on 8/19/21 at 112:58 p.m. The policy included but was not limited to: "Purpose: To protect the asset of the building. To provide a safe environment for residents, families, visitors, and staff. To meet life safety code requirements. Policy: It is the job of all staff to identify areas of concern regarding the maintenance of the building. Preventive maintenance will occur throughout the year. In the office there is a binder containing several maintenance records for items that have to be checked monthly, quarterly and yearly...Any areas a resident identifies as needing maintenance in their apartment should be brought to the attention of the management team. Maintenance forms should be given to residents and made available on the bulletin board for residents to fill out. Emergency things will be fixed as soon as possible, and lower maintenance items will be fixed within a timely manner...." This Residential tag relates to Complaint IN00360152.			

	Based on observation, interview, and record review, the facility failed to ensure resident rooms and common areas were clean and in good repair, failed to provide housekeeping and maintenance services for 6 of 6 residents reviewed, and had the potential to affect all 27 residents in the facility. (Residents M, L, D, G, H, and N) Findings include: During the initial tour on 8/18/21 at 11:00 a.m., an odor that was unrecognizable was observed in the hallway where rooms 1 through 12 are located, and the hallway where rooms 31 through 40 are located. This odor was present all 3 days of the survey. On 8/18/21 at 10:30 a.m., Resident M indicated their apartment has not been cleaned in 4 weeks and they have been trying to clean up after themselves. Resident M said it is in their service agreement to have housekeeping and they aren't receiving that service. On 8/18/21 at 11:10 a.m., Resident L indicated they are supposed to have someone come in to help with housekeeping, and they haven't had housekeeping for 5 or 6 weeks. They also have no maintenance and they have had			

to change their own light bulbs.

On 8/18/21 at 1:10 p.m., Resident D's apartment was observed to have these problems:

- The carpet in the living room had debris scattered all over it. Resident D indicated he hasn't had his apartment cleaned in 6 weeks.

- The screen door in the living room, that opened to the patio, wouldn't slide into place so the door to the outside could be left open. The bottom of the screen was loose, and the rubber seals that held the screen in place on the door were hanging down on both sides of the door frame.

- The commode had a large area of dried feces above the water line. The toilet seat was loose on the toilet. Resident D said he has slid off the toilet onto the floor and he just puts it back together when it comes apart. He said he doesn't tell staff when he falls. There is an odor in his bathroom because he can't clean it, and said they brought him a can of Febreze to cover it up.

- Light bulbs were out in the kitchen and in the overhead bedroom light.

Resident D said there is a sewer odor in the hallway that has been there for several months. It

	will get better but it doesn't completely go away. They are told it has something to do with empty apartments. On 8/18/21 at 1:20 p.m., Resident G indicated there was a lack of housekeeping and she was unsure how long it has been since the facility cleaned her room, but it was between 4 and 6 weeks ago. She said her daughter came by and deep cleaned about 2 weeks ago. Her daughter had told her that her apartment needed cleaned, and it is very dirty, and she was embarrassed. She said she has always kept a tidy house and was upset her apartment got so untidy. She said her family has been doing her laundry since they do not have any staff; they don't have housekeeping staff, laundry staff, and they are without a maintenance man. On 8/18/21 at 1:40 p.m., Resident Assistant 5 indicated the facility currently doesn't have a Maintenance person or a housekeeper and said they do what they can to keep up. On 8/19/21 at 1:15 p.m., Resident O said there was an odor in the facility that has been here awhile. On 8/20/21 at 10:30 a.m., Resident H indicated her apartment has not been cleaned once since she moved in.			

	(Resident moved into facility in April 2021) On 8/20/21 at 11:20 a.m., Resident N indicated she has had some issues with maintenance in the apartment, but nothing major and her daughter would be in soon to complete those if the facility doesn't complete those, including replacing her curtain rods. On 8/20/21 at 1:55 p.m., the Administrator indicated they had fixed the broken toilet once, they had replaced the toilet seat. He said because there is no Maintenance person right now, it's "all hands-on deck" to work together to get things done. An "Assisted Living Establishment Contract" was provided to each resident upon admission and is signed by the resident and a Management Representative. The contract included but wasn't limited to: "...5. FEES AND SERVICES PROVIDED - The base monthly fee for a resident is calculated by the size of apartment rented and level of care required...Services included for all residents, regardless of monthly fee include: (A) Weekly cleaning of the unit. (B) Weekly changing of bed and bath linens and personal laundry...."			

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	records for items that have to be checked monthly, quarterly and yearly...Any areas a resident identifies as needing maintenance in their apartment should be brought to the attention of the management team. Maintenance forms should be given to residents and made available on the bulletin board for residents to fill out. Emergency things will be fixed as soon as possible, and lower maintenance items will be fixed within a timely manner...." This Residential tag relates to Complaint IN00360152.			

R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review the facility failed to assess a resident for self-administration of insulin for 1 of 4 residents reviewed for self-medication administration. (Resident E) Findings include: On 8/18/21 at 11:45 a.m., Resident E was observed for insulin administration. QMA 1 placed the needle on top of the Novolog insulin pen, handed it to Resident E and instructed her to dial it to 8. Resident E dialed	R 0216	R216: The facility failed to assess Resident E for self-administration of insulin. This failure to assess Resident E had the potential to affect no other residents. 1. The facility Nursing staff will perform a Self-Administration of Medication Assessment on Resident E to include her ability to self-administer insulin. 2. The facility & corporate Administration and nursing staff will review all resident charts to make sure that all residents that self-administer/inject medication have an assessment on file. And residents that self-administer medications, and do not have a Self-Administration of Medication Assessment, will be assessed by facility and/or corporate nursing staff, or a physician.	09/27/2021

	the insulin pen to 9 and QMA 1 instructed her to dial it back one click. Resident E said her vision is bad and that she isn't able to see the numbers. Resident E then dialed the dose to 7, and QMA 1 directed her to dial it to 8. Resident E asked QMA 1 if it was right, then cleansed her skin on her middle left abdomen with an alcohol swab and gave herself the insulin just below the skin near her umbilicus. QMA 1 handed the needle cap to Resident E and Resident E recapped the used needle and QMA 1 disposed of the needle. Resident E's record was reviewed on 8/19/21 at 10:00 a.m. The record indicated Resident E had diagnoses that included, but were not limited to, diabetes mellitus with peripheral neuropathy, chronic kidney disease stage 5, and depression. August 2021 Physician's medication orders included an order for "Novolog Flexpen, inject 8 units subcutaneously 3 times a day, (Start once Humalog finished)" with an order date of 7/14/21. No self-medication administration assessment was located in Resident E's record. On 8/19/21 at 10:49 a.m., the DoN (Director of Nursing) indicated prior to her coming to		3. The corporate Administration will retrain facility Administration and nursing staff on the requirements of a Self-Administration of Medication Assessment upon admission, annually and upon an alternate need. The facility Nursing staff, or physician will perform a Self-Administration of Medication Assessment on each resident upon admission, annually and upon an alternate need. 4. The facility Administration will monitor resident charts for a proper Self-Administration of Medication Assessment. 5. The corporate Administration will audit charts quarterly for 12 months, and annually forward, for compliance of this deficiency. 6. R216 Systemic changes to be complete by 9/27/2021.	

	the facility, she didn't believe the self-administration assessments were being done, but since she's been here, they are doing them. She stated that they administer medications for the resident in question except for her insulin, and the nurse or QMA would dial in the insulin pen then give to the resident to self-administer the shot. On 8/19/21 at 1:00 p.m., the DoN indicated Resident E doesn't have a self-administration record because she doesn't give her own meds.			

	A policy for "Assistance with Medication" was provided by the Corporate Operations 2 on 8/20/21 at 2:40 p.m. The policy included but was not limited to: "Procedure: Residents may manage their own medications unless the physician writes an order for the facility to provide oversight or assistance with self-administration of medication...The facility medication administration policies must be approved by a physician, pharmacist, or licensed health care professional and needs to address...4. Assisting with Self-Administration of medication...Administration of Medication...Confirming that residents have obtained and are taking the dosage as prescribed...." Based on observation, interview, and record review the facility failed to assess a resident for self-administration of insulin for 1 of 4 residents reviewed for self-medication administration. (Resident E) Findings include: On 8/18/21 at 11:45 a.m., Resident E was observed for insulin administration. QMA 1 placed the needle on top of the Novolog insulin pen, handed it to Resident E and instructed her to dial it to 8. Resident E dialed the insulin pen to 9 and QMA 1			

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	self-administration assessments were being done, but since she's been here, they are doing them. She stated that they administer medications for the resident in question except for her insulin, and the nurse or QMA would dial in the insulin pen then give to the resident to self-administer the shot. On 8/19/21 at 1:00 p.m., the DoN indicated Resident E doesn't have a self-administration record because she doesn't give her own meds. A policy for "Assistance with Medication" was provided by the Corporate Operations 2 on 8/20/21 at 2:40 p.m. The policy included but was not limited to: "Procedure: Residents may manage their own medications unless the physician writes an order for the facility to provide oversight or assistance with self-administration of medication...The facility medication administration policies must be approved by a physician, pharmacist, or licensed health care professional and needs to address...4. Assisting with Self-Administration of medication...Administration of Medication...Confirming that residents have obtained and are taking the dosage as prescribed...."			

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 interview and record review, the facility failed to ensure PRN (as needed) medications, administered by a QMA (qualified medication aide), included documentation in the resident's clinical record that a facility licensed nurse authorized the medication to be given prior to administration of the medication. This affected 2 of 5 residents reviewed for medications. (Residents F and H) Findings include: 1. Resident F's record was reviewed on 8/19/21 at 11:00 a.m. and indicated Resident F had diagnoses that included, but were not limited to, high blood pressure, diabetes mellitus, and end stage renal	R 0246	R246: The facility failed to ensure PRN (as needed) medications, administered by a QMA (qualified medication aide), included documentation in the resident’s clinical record that a facility licensed nurse authorized the medication to be given prior to the administration of the medication. 1. The facility nurse providing authorization or Resident F and Resident H, as labeled in the State Findings, resigned without notice during the Complaint Survey. The former facility nurse has refused to return and complete documentation of the authorization of PRN medications. Therefore, the facility is unable to correct the deficiency of past records. 2. The facility Administration and nursing staff will review MARS and resident clinical records of all residents and the current nursing staff will correct the documentation, if able and applicable. 3. The QMA’s will phone a licensed nurse for	09/27/2021

	failure. Physician's orders, dated 4/20/21, indicated an order for Hydrocodone-APAP 7.5-325 milligram tablet, take 1 tablet by mouth 2 times a day as needed on non-dialysis days. The following dates on the Medication Administration Records (MARs) had been initialed as given by a Qualified Medication Aide (QMA): June 7, 15 (twice), 19, and 26, 2021. There was no documentation in the progress notes of which nurse approved the PRN dose, the time the medication was given, and no documentation the nurse signed off for the medication that indicated she had approved for the administration of the medication prior to it being given. Physician's orders, dated 7/9/21, indicated an order for Morphine Sulfate oral solution, 100 milligrams in 5 milliliters, give 0.5 milliliters by mouth/under the tongue every 2 hours as needed for pain or agitation. On the MARs for July 10, 2021, the Morphine had been initialed twice as given by a QMA without documentation in the progress notes that a nurse had approved the PRN dose, the time the medication was given, and no documentation the nurse signed off for the medication that indicated she had approved for		authorization of PRN medications before administering. Following, the QMA will document the administration in the residents MAR (medication administration record). Next, the QMA will document the nurse contact, to include the time and date in the Nursing Communication Book. The QMA will document the communication in the MAR, and the nurse will initial following his/her return to the facility; or the nurse will chart the PRN med authorization in the resident's clinical record/progress notes, following his/her return to the facility. The QMAs and facility nurse(s) will be retrained by corporate administration on the PRN medication policy. 4. The facility Administration and nursing staff will audit MAR and resident clinical records for completion and accuracy. The nursing staff will properly document as outlined in the systemic changes of this Plan of Correction. 5. Facility Nurse will monitoring monthly, ongoing. And corporate Administration will monitor quarterly for the	

	the medication to be given prior to the administration of the medication. 2. Resident H's record was reviewed on 8/19/21 at 2:15 p.m. The record indicated Resident H had diagnoses that included, but were not limited to, chronic renal failure, heart failure, high blood pressure, anxiety, depression, and chronic pain. Physician's orders, with no date, indicated an order for Morphine IR (immediate release), 30 milligrams by mouth, give 1 tablet every 6 hours for pain as needed. Review of August 2021 MARs indicated the Morphine had been given on 8/5, 8/9, and 8/13/21 with no documentation of the prior approval for the QMA to give the medication the time the medication was given, nor documentation the nurse signed off that she had approved the medication to be given. On 8/19/21 at 1:33 p.m., the Director of Nursing indicated the QMAs can call her or LPN 4 when they need to give a PRN medication, that they are available at all hours. She said when they are in the facility next, they will sign off on the PRN. On 8/19/21 at 12:58 p.m., the Administrator provided a copy of		next year, and annually ongoing. 6. R246 Systemic changes to be complete by 9/27/2021.	

	a policy for "Assistance with Medication", that included, but was not limited to: "...PRN Medication: When a resident wishes to have a PRN medication, the QMA obtain [sic] authorization by a licensed nurse or physician. All contacts with a nurse or physician not on premises for authorization to administer PRN's shall be documented in the nursing notes indicating the time and date of the contact. The licensed nurse must initial as soon as possible when in the facility." This Residential tag relates to Complaint IN00360290. Based on interview and record review, the facility failed to ensure PRN (as needed) medications, administered by a QMA (qualified medication aide), included documentation in the resident's clinical record that a facility licensed nurse authorized the medication to be given prior to administration of the medication. This affected 2 of 5 residents reviewed for medications. (Residents F and H) Findings include: 1. Resident F's record was reviewed on 8/19/21 at 11:00 a.m. and indicated Resident F had diagnoses that included, but were not limited to, high			

	blood pressure, diabetes mellitus, and end stage renal failure. Physician's orders, dated 4/20/21, indicated an order for Hydrocodone-APAP 7.5-325 milligram tablet, take 1 tablet by mouth 2 times a day as needed on non-dialysis days. The following dates on the Medication Administration Records (MARs) had been initialed as given by a Qualified Medication Aide (QMA): June 7, 15 (twice), 19, and 26, 2021. There was no documentation in the progress notes of which nurse approved the PRN dose, the time the medication was given, and no documentation the nurse signed off for the medication that indicated she had approved for the administration of the medication prior to it being given. Physician's orders, dated 7/9/21, indicated an order for Morphine Sulfate oral solution, 100 milligrams in 5 milliliters, give 0.5 milliliters by mouth/under the tongue every 2 hours as needed for pain or agitation. On the MARs for July 10, 2021, the Morphine had been initialed twice as given by a QMA without documentation in the progress notes that a nurse had approved the PRN dose, the time the medication was given, and no documentation the nurse signed			

	off for the medication that indicated she had approved for the medication to be given prior to the administration of the medication. 2. Resident H's record was reviewed on 8/19/21 at 2:15 p.m. The record indicated Resident H had diagnoses that included, but were not limited to, chronic renal failure, heart failure, high blood pressure, anxiety, depression, and chronic pain. Physician's orders, with no date, indicated an order for Morphine IR (immediate release), 30 milligrams by mouth, give 1 tablet every 6 hours for pain as needed. Review of August 2021 MARs indicated the Morphine had been given on 8/5, 8/9, and 8/13/21 with no documentation of the prior approval for the QMA to give the medication the time the medication was given, nor documentation the nurse signed off that she had approved the medication to be given. On 8/19/21 at 1:33 p.m., the Director of Nursing indicated the QMAs can call her or LPN 4 when they need to give a PRN medication, that they are available at all hours. She said when they are in the facility next, they will sign off on the PRN.			

	On 8/19/21 at 12:58 p.m., the Administrator provided a copy of a policy for "Assistance with Medication", that included, but was not limited to: "...PRN Medication: When a resident wishes to have a PRN medication, the QMA obtain [sic] authorization by a licensed nurse or physician. All contacts with a nurse or physician not on premises for authorization to administer PRN's shall be documented in the nursing notes indicating the time and date of the contact. The licensed nurse must initial as soon as possible when in the facility." This Residential tag relates to Complaint IN00360290.			
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 there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to document a medication error in a resident's clinical record for 1 of 1 resident reviewed. (Resident B)	R 0247	R247: The facility failed to document a medication error in a resident’s clinical record for resident B. 1.The medication error of Resident B, on 8/10/21 will be recorded in the resident’s clinical record/progress notes. 2.The facility Administration and Nursing staff will review all Medication Error Reports to make sure they are properly documented in the residents’ clinical records, and document, if applicable.	09/27/2021

	Findings include: During an interview, on 8/19/21 at 10:05 a.m., Resident B indicated that on August 10, 2021, her Gabapentin was not being given at the correct dose. She said the medication error was corrected as soon as they found it. Resident B's record was reviewed on 8/19/21 at 12:50 p.m. The record indicated Resident B had diagnoses that included, but were not limited to, neuropathy, osteoarthritis, migraine headaches, chronic fatigue syndrome, and degenerative joint disease. Resident B had a physician's order for gabapentin (anticonvulsant), 300 milligrams, take 2 capsules by mouth 2 times a day, with a start date of 6/18/20. On 7/21/21, the order was changed to gabapentin 600 milligrams, 1 capsule three times a day. On 8/11/21, the order was changed to gabapentin 600 milligrams, 1 capsule by mouth twice a day. An "Accident/Incident Report" was provided by the Director of Nursing on 8/19/21 at 10:49 a.m. and indicated the date of the Accident was 8/10/21 at 1:00 p.m. The description of the Accident/Incident included: "[Name of QMA 3] noticed at morning med pass that		3.The facility corporate management team will retrain the facility Administration and nursing staff on the clinical record/progress note med error documentation policy of Timber Creek Village. 4.The facility Administration, Nursing staff and corporate management team will monitor Medication Error Reports forward and make sure they are properly documented in resident clinical records. 5.Facility Administration will monitor monthly, for one year. Corporate Administration will monitor annually, ongoing. 6.R247 Systemic changes to be corrected by 09/27/2021.	

	[Resident B's] gabapentin was not in her pill pack (which was a new pill pack delivered at midnight 8/10). [QMA 3] was instructed by [Director of Nurses] to call pharmacy regarding missing meds. Pharmacy informed [QMA 3] that [Resident B] should have been receiving 600 mg (milligrams) gabapentin TID per new orders that were sent & received 7/19. [Resident B] has been receiving gabapentin from the pill pack that needed to be discarded from 7/19 to present. This was the previous dose that was 300 for morning and afternoon dose, and [Resident B] was offered 600 mg from the bulk pack in the evenings per orders which she had been refusing. She was under the impression she had been receiving 600 mg w (with)/each dose. Was First Aid Administered? - No...Was Person Hospitalized? - No. Was Doctor Notified? Date: 8/10/21 at 1:30 p.m. Doctors Name: [Name of Doctor] office notified [no] new orders at this time. MD was not concerned - Res had been refusing 8P dose eve[ning]...." The corrective action taken was "8/10 Meeting with nursing team to further investigate why med orders were not being followed." During an interview on 8/19/21 at 11:15 a.m., the Director of Nursing indicated they keep the			

	medication error reports in a binder in the office where the clinical records are kept, but there probably isn't one in the chart. A policy for "Assistance With Medication" was provided by the Administrator on 8/19/21 at 12:58 p.m. The policy indicated but was not limited to: "Medication Error Reporting: All medication errors that occur for residents receiving medication supervision from our facility are required to be reported. A medication error includes: Wrong Medication, Wrong Dosage, Wrong Time (within 1 hour before or 1 hour after the prescribed time is acceptable), Wrong Route, Missed Medication. Each facility has their own Error Log Sheet that must be filled out each time a medication error occurs...If a medication error occurs, a company Medication Error form should be filled out. These should be kept in a MEDICATION ERROR binder in the office. A copy needs to go into the resident's chart as well...A note in the resident's record must also be made regarding the error. In that case BOTH forms (facility form and state form) should be kept in the Medication Error binder...."			

	This Residential tag relates to Complaint IN00360152 and Complaint IN00360290. Based on record review and interview, the facility failed to document a medication error in a resident's clinical record for 1 of 1 resident reviewed. (Resident B) Findings include: During an interview, on 8/19/21 at 10:05 a.m., Resident B indicated that on August 10, 2021, her Gabapentin was not being given at the correct dose. She said the medication error was corrected as soon as they found it. Resident B's record was reviewed on 8/19/21 at 12:50 p.m. The record indicated Resident B had diagnoses that included, but were not limited to, neuropathy, osteoarthritis, migraine headaches, chronic fatigue syndrome, and degenerative joint disease.			

	Resident B had a physician's order for gabapentin (anticonvulsant), 300 milligrams, take 2 capsules by mouth 2 times a day, with a start date of 6/18/20. On 7/21/21, the order was changed to gabapentin 600 milligrams, 1 capsule three times a day. On 8/11/21, the order was changed to gabapentin 600 milligrams, 1 capsule by mouth twice a day. An "Accident/Incident Report" was provided by the Director of Nursing on 8/19/21 at 10:49 a.m. and indicated the date of the Accident was 8/10/21 at 1:00 p.m. The description of the Accident/Incident included: "[Name of QMA 3] noticed at morning med pass that [Resident B's] gabapentin was not in her pill pack (which was a new pill pack delivered at midnight 8/10). [QMA 3] was instructed by [Director of Nurses] to call pharmacy regarding missing meds. Pharmacy informed [QMA 3] that [Resident B] should have been receiving 600 mg (milligrams) gabapentin TID per new orders that were sent & received 7/19. [Resident B] has been receiving gabapentin from the pill pack that needed to be discarded from 7/19 to present. This was the previous dose that was 300 for morning and afternoon dose, and [Resident B] was offered 600 mg from the bulk pack in the evenings per			

	orders which she had been refusing. She was under the impression she had been receiving 600 mg w (with)/each dose. Was First Aid Administered? - No...Was Person Hospitalized? - No. Was Doctor Notified? Date: 8/10/21 at 1:30 p.m. Doctors Name: [Name of Doctor] office notified [no] new orders at this time. MD was not concerned - Res had been refusing 8P dose eve[ning]...." The corrective action taken was "8/10 Meeting with nursing team to further investigate why med orders were not being followed." During an interview on 8/19/21 at 11:15 a.m., the Director of Nursing indicated they keep the medication error reports in a binder in the office where the clinical records are kept, but there probably isn't one in the chart. A policy for "Assistance With Medication" was provided by the Administrator on 8/19/21 at 12:58 p.m. The policy indicated but was not limited to: "Medication Error Reporting: All medication errors that occur for residents receiving medication supervision from our facility are required to be reported. A medication error includes: Wrong Medication, Wrong Dosage, Wrong Time (within 1 hour before or 1 hour after the prescribed time is acceptable),			

	Wrong Route, Missed Medication. Each facility has their own Error Log Sheet that must be filled out each time a medication error occurs...If a medication error occurs, a company Medication Error form should be filled out. These should be kept in a MEDICATION ERROR binder in the office. A copy needs to go into the resident's chart as well...A note in the resident's record must also be made regarding the error. In that case BOTH forms (facility form and state form) should be kept in the Medication Error binder...." This Residential tag relates to Complaint IN00360152 and Complaint IN00360290.			
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. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.	R 0349	R349: The facility failed to ensure Medication Administration (MAR) Records and Narcotic/Controlled Substance Records were completely and accurately documented for 2 of 10 residents (E and H) reviewed for completeness of clinical records. 1.If the QMA or LPN that administered the medications of resident E or resident H as listed in the state findings, are still employed with the facility, they will properly document the back logs for MARS and/or Narcotic/Controlled Substance	09/27/2021

	Based on record review and interview, the facility failed to ensure Medication Administration Records and Narcotic/Controlled Substance Records were completely and accurately documented for 2 of 10 residents reviewed for completeness of clinical records. (Residents E, and H) Findings include: 1. Resident E's record was reviewed on 8/19/21 at 10:00 a.m. Resident E had diagnoses that included, but were not limited to, diabetes mellitus with peripheral neuropathy, chronic kidney disease stage 5, and depression. The following dates in the Medication Administration Records (MARs), dated July 2 through July 31, 2021, lacked the nurse's or QMA's initials that would have indicated the following medications had been administered: - July 9, 10, no initials, or amount to indicate Humalog 100 units/milliliter had been given for the 7:00 a.m. dose. - July 5, 6, 7, 8, 13, no initials or amount was documented to show the Humalog 100 units/milliliter had been given for the 4:00 p.m. dose. - July 10, no initials, or amount of insulin was documented for		Records. 2.The facility Administration, nursing team and corporate management team will audit MARS and Narcotic/Controlled Substance Records of all residents for completion and accuracy. Any incomplete and/or inaccurate documentation will be corrected, if applicable (employees still employed with the facility). 3.The QMA and nursing staff will be retrained by corporate administration on proper MAR and Narcotic/Controlled Substance Records and proper documentation of. 4.Facility Administration and Nursing staff will audit medication logs for complete and accurate records forward. If inaccurate or complete data is found, the staff will be directed to correct. 5.Facility Administration or nursing staff will monitoring monthly, ongoing. And corporate Administration will monitor quarterly for the next year, and annually ongoing. 6.R349 Systemic changes to be corrected by 09/27/2021.	

	the Humalog 100 units/milliliter had been given for the 11:00 a.m. dose. - July 5,14, 15, 16, 24, and 29, Carvedilol 12.5 milligrams tablet, 1 by mouth 2 times a day with meal/food was not initialed as administered for the 5:00 p.m. doses. The following dates in the MARs for August 2021 lacked the nurse's or QMA's initials that would have indicated the following medications had been administered: - August 6, the Novolog Flexpen, inject 8 units subcutaneously 3 times a day, the 7:00 a.m. dose was not initialed as given. - August 7, Levothyroxine 25 micrograms tablet, take 1 tablet by mouth once daily, was not initialed as given at 6:00 a.m. - August 8, Pantoprazole 10 milligrams, take 1 tablet by mouth once daily at bedtime was not initialed as given at 8:00 p.m. - August 7, Carvedilol 12.5 milligrams tablet, 1 by mouth 2 times a day with meal/food was not initialed as administered for the 8:00 a.m. dose. 2. Resident H's record was reviewed on 8/19/21 at 2:15 p.m. The record indicated			

	Resident H had diagnoses that included, but were not limited to, chronic renal failure, heart failure, high blood pressure, anxiety, depression, and chronic pain. Physician's orders for Resident H included an order for Morphine Sulfate 30 milligrams immediate release tablets, give 1 tablet by mouth every 6 hours as needed for breakthrough pain. A comparison between the MAR and the Narcotic/Controlled Substance Record indicated these discrepancies: August 1 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record. August 2 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record. August 3 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record. August 4 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record.			

	August 5 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 6 - 1 morphine tablet was signed out on the MAR, 3 were signed out on the Narcotic record. August 7 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 8 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 9 - 2 morphine tablets were signed out on the MAR, 3 were signed out on the Narcotic record. August 10 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 11 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 13 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 15 - No morphine signed out on the MAR, 2 were signed out on the Narcotic record.			

	The Director of Nursing provided a Narcotic/Controlled Substance Record on 8/18/21 at 11:31 a.m. On the line dated 8/17/21 at 8:00 a.m., there was no signature, and 2 clonazepam 0.5 milligram tablets had been subtracted from the line. Another copy of the same Narcotic Sheet, 1 day later, indicated a name had been filled in 1 day after the form had been provided. On 8/19/21 at 1:00 p.m., the Director of Nursing indicated that there would be some holes in the MARs, and the nurse that left holes is no longer here. On 8/20/21 at 12:45 p.m., LPN 4 indicated she counts [narcotics] every shift on and off with another person and the counts have been fine every day she worked. She said she is confused about what is going on with the narcotic sheet and why the name was dropped down like that. She verified it was her signature but stated that it is not her writing on the date/time side of the medication. A policy for "Assistance with Medication" was provided by the Administrator on 8/19/21 at 12:58 p.m. The policy included but was not limited to: "...The facility medication administration policies must be approved by a physician, pharmacist, or licensed health care			

professional and needs to address...5. Recording of medication assistance provided to residents and maintenance of medication records...Administration of Medication...Documenting in writing that the resident has taken (or refused to take) the medication...."

A policy for "Resident Records" was provided on 8/19/21 at 12:58 p.m. The policy included but was not limited to: "Procedure: 1. All resident files will be kept in separate binders in the office and must be maintained by the facility from the date of execution until three years after the date the contract is terminated...."

This Residential tag relates to Complaint IN00360290.

Based on record review and interview, the facility failed to ensure Medication Administration Records and Narcotic/Controlled Substance Records were completely and accurately documented for 2 of 10 residents reviewed for completeness of clinical records. (Residents E, and H)

Findings include:

1. Resident E's record was reviewed on 8/19/21 at 10:00 a.m. Resident E had diagnoses that included, but were not limited to, diabetes mellitus with

peripheral neuropathy, chronic kidney disease stage 5, and depression.

The following dates in the Medication Administration Records (MARs), dated July 2 through July 31, 2021, lacked the nurse's or QMA's initials that would have indicated the following medications had been administered:

- July 9, 10, no initials, or amount to indicate Humalog 100 units/milliliter had been given for the 7:00 a.m. dose.

- July 5, 6, 7, 8, 13, no initials or amount was documented to show the Humalog 100 units/milliliter had been given for the 4:00 p.m. dose.

- July 10, no initials, or amount of insulin was documented for the Humalog 100 units/milliliter had been given for the 11:00 a.m. dose.

- July 5,14, 15, 16, 24, and 29, Carvedilol 12.5 milligrams tablet, 1 by mouth 2 times a day with meal/food was not initialed as administered for the 5:00 p.m. doses.

The following dates in the MARs for August 2021 lacked the nurse's or QMA's initials that would have indicated the following medications had been administered:

- August 6, the Novolog Flexpen, inject 8 units subcutaneously 3 times a day, the 7:00 a.m. dose was not initialed as given.

- August 7, Levothyroxine 25 micrograms tablet, take 1 tablet by mouth once daily, was not initialed as given at 6:00 a.m.

- August 8, Pantoprazole 10 milligrams, take 1 tablet by mouth once daily at bedtime was not initialed as given at 8:00 p.m.

- August 7, Carvedilol 12.5 milligrams tablet, 1 by mouth 2 times a day with meal/food was not initialed as administered for the 8:00 a.m. dose.

2. Resident H's record was reviewed on 8/19/21 at 2:15 p.m. The record indicated Resident H had diagnoses that included, but were not limited to, chronic renal failure, heart failure, high blood pressure, anxiety, depression, and chronic pain.

Physician's orders for Resident H included an order for Morphine Sulfate 30 milligrams immediate release tablets, give 1 tablet by mouth every 6 hours as needed for breakthrough pain.

A comparison between the MAR and the Narcotic/Controlled Substance Record indicated

these discrepancies:

August 1 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record.

August 2 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record.

August 3 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record.

August 4 - no morphine was initialed as given on the MAR, 1 was signed out on the Narcotic record.

August 5 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record.

August 6 - 1 morphine tablet was signed out on the MAR, 3 were signed out on the Narcotic record.

August 7 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record.

August 8 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record.

August 9 - 2 morphine tablets were signed out on the MAR, 3

	were signed out on the Narcotic record. August 10 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 11 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 13 - 1 morphine tablet was signed out on the MAR, 2 were signed out on the Narcotic record. August 15 - No morphine signed out on the MAR, 2 were signed out on the Narcotic record. The Director of Nursing provided a Narcotic/Controlled Substance Record on 8/18/21 at 11:31 a.m. On the line dated 8/17/21 at 8:00 a.m., there was no signature, and 2 clonazepam 0.5 milligram tablets had been subtracted from the line. Another copy of the same Narcotic Sheet, 1 day later, indicated a name had been filled in 1 day after the form had been provided. On 8/19/21 at 1:00 p.m., the Director of Nursing indicated that there would be some holes in the MARs, and the nurse that left holes is no longer here. On 8/20/21 at 12:45 p.m., LPN 4 indicated she counts			

	[narcotics] every shift on and off with another person and the counts have been fine every day she worked. She said she is confused about what is going on with the narcotic sheet and why the name was dropped down like that. She verified it was her signature but stated that it is not her writing on the date/time side of the medication. A policy for "Assistance with Medication" was provided by the Administrator on 8/19/21 at 12:58 p.m. The policy included but was not limited to: "...The facility medication administration policies must be approved by a physician, pharmacist, or licensed health care professional and needs to address...5. Recording of medication assistance provided to residents and maintenance of medication records...Administration of Medication...Documenting in writing that the resident has taken (or refused to take) the medication...."			

	A policy for "Resident Records" was provided on 8/19/21 at 12:58 p.m. The policy included but was not limited to: "Procedure: 1. All resident files will be kept in separate binders in the office and must be maintained by the facility from the date of execution until three years after the date the contract is terminated...." This Residential tag relates to Complaint IN00360290.			
R 0351	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(c)(d) (c) The facility must safeguard clinical record information against loss, destruction, or unauthorized use. (d) The facility must keep confidential all information contained in the resident ' s records, regardless of the form or storage method of the records, and release such records only as permitted by law. Based on record review and interview, the facility failed to ensure narcotic count records were maintained in the clinical record for 2 of 4 residents reviewed for documentation of narcotic use. (Residents F and H) Findings include:	R 0351	R351: The facility failed to ensure narcotic records were maintained in the clinical record for residents F and H. 1.If the QMA or LPN that administered the medications of resident F and/or resident H, as listed in the state findings, are still employed with the facility, they will properly document narcotics in the clinical records. 2.The facility Administration, nursing team and corporate management team will audit clinical records of all residents, for completion and accuracy. Any incomplete and/or inaccurate documentation will be corrected, if applicable (employees still employed with the facility).	09/27/2021

	1. Resident F's record was reviewed on 8/19/21 at 11:00 a.m. and indicated Resident F had diagnoses that included, but were not limited to, high blood pressure, diabetes mellitus, end stage renal failure. Resident F had a physician's order for Lorazepam 2 milligrams/milliliter, oral concentrate, take 0.25 milliliters by mouth every 2 hours as needed for anxiety, with a start date of 7/9/21. A Medication Destruction Record, with documentation dated 7/16/21, indicated that Lorazepam 2 milligrams/milliliter, oral was destroyed, and the reason was RHC (respirations have ceased). Physician's orders, dated 7/9/21, indicated an order for Morphine Sulfate oral solution, 100 milligrams in 5 milliliters, give 0.5 milliliters by mouth/under the tongue every 6 hours for pain or shortness of breath. There was no narcotic sign off sheet for the Lorazepam or the morphine sulfate in the clinical record. On 8/20/21 at 10:05 a.m., the Director of Nursing indicated she couldn't find some of the narcotic sheets, that QMAs have a habit of taking them out		3.The facility corporate management team will retrain facility QMA and nursing staff on properly documenting narcotics in resident’s clinical records. 4.The facility and corporate administration and nursing team will monitor medication and clinical records. 5.Medication records will be monitored monthly, forward and ongoing by the facility and/or Administration team, and annually by corporate Administration. 6.R351 Systemic changes to be corrected by 09/27/2021.	

	of the narcotic book and putting them in the chart. 2. Resident H's record was reviewed on 8/19/21 at 2:15 p.m. The record indicated Resident H had diagnoses that included, but were not limited to, chronic renal failure, heart failure, high blood pressure, anxiety, depression, and chronic pain. Physician's orders, with no date, indicated an order for Morphine ER (extended release), 60 milligrams by mouth, give 1 tablet twice a day. Physician's orders, with no date, indicated an order for clonazepam 0.5 milligram tablet, give 2 tablets by mouth three times a day. There was no narcotic sign off sheet for the morphine ER from 7/27/21 through 8/10/21. There was no narcotic sign off sheet for the clonazepam. During an interview, on 8/19/21 at 3:43 p.m., the Director of Nursing said she had provided all the narcotic sheets they had for Resident H. A policy for "Residential Records" was provided by the Administrator on 8/19/21 at 12:58 a.m. The policy included but was not limited to: "Procedure: 1. All resident files			

will be kept in separate binders in the office and must be maintained by the facility form the date of execution until three years after the date the contract is terminated...Storing Resident Records...The facility must safe guard clinical record information against loss, destruction or unauthorized use..."

Based on record review and interview, the facility failed to ensure narcotic count records were maintained in the clinical record for 2 of 4 residents reviewed for documentation of narcotic use. (Residents F and H)

Findings include:

1. Resident F's record was reviewed on 8/19/21 at 11:00 a.m. and indicated Resident F had diagnoses that included, but were not limited to, high blood pressure, diabetes mellitus, end stage renal failure.

Resident F had a physician's order for Lorazepam 2 milligrams/milliliter, oral concentrate, take 0.25 milliliters by mouth every 2 hours as needed for anxiety, with a start date of 7/9/21.

A Medication Destruction Record, with documentation dated 7/16/21, indicated that Lorazepam 2 milligrams/milliliter, oral was destroyed, and the reason was

RHC (respirations have ceased).

Physician's orders, dated 7/9/21, indicated an order for Morphine Sulfate oral solution, 100 milligrams in 5 milliliters, give 0.5 milliliters by mouth/under the tongue every 6 hours for pain or shortness of breath.

There was no narcotic sign off sheet for the Lorazepam or the morphine sulfate in the clinical record.

On 8/20/21 at 10:05 a.m., the Director of Nursing indicated she couldn't find some of the narcotic sheets, that QMAs have a habit of taking them out of the narcotic book and putting them in the chart.

2. Resident H's record was reviewed on 8/19/21 at 2:15 p.m. The record indicated Resident H had diagnoses that included, but were not limited to, chronic renal failure, heart failure, high blood pressure, anxiety, depression, and chronic pain.

Physician's orders, with no date, indicated an order for Morphine ER (extended release), 60 milligrams by mouth, give 1 tablet twice a day.

Physician's orders, with no date, indicated an order for clonazepam 0.5 milligram tablet,

	give 2 tablets by mouth three times a day. There was no narcotic sign off sheet for the morphine ER from 7/27/21 through 8/10/21. There was no narcotic sign off sheet for the clonazepam. During an interview, on 8/19/21 at 3:43 p.m., the Director of Nursing said she had provided all the narcotic sheets they had for Resident H. A policy for "Residential Records" was provided by the Administrator on 8/19/21 at 12:58 a.m. The policy included but was not limited to: "Procedure: 1. All resident files will be kept in separate binders in the office and must be maintained by the facility form the date of execution until three years after the date the contract is terminated...Storing Resident Records...The facility must safe guard clinical record information against loss, destruction or unauthorized use..."			
R 0357	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(j)(1-3) (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and	R 0357	R357: The facility failed to ensure complete documentation of a resident’s death was in the clinical record for Resident F. 1.The facility will properly document the death of Resident F in her clinical record.	09/27/2021

	legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on record review and interview, the facility failed to ensure complete documentation of a resident's death was in the clinical record for 1 of 1 resident reviewed. (Resident F) Findings include: Resident F's record was reviewed on 8/19/21 at 11:00 a.m. Resident F had diagnoses that included, but were not limited to, high blood pressure, diabetes mellitus, and end stage renal failure. A "Provisional Notification of Death - Burial Transit Permit" indicated Resident F's death occurred on 7/10/21 at 6:13 p.m. The progress notes in the clinical record lacked documentation of the resident's condition, vital signs and symptoms preceding death, and had no documentation of who was notified, and the time of death. During an interview, on 8/19/21		2.The facility will review charts of deceased residents for proper documentation of death. No other residents are missing the documentation of death. In the event this documentation was missing, it would have been corrected. 3.The facility corporate management team will retrain facility Administration and nursing staff on properly documenting a resident death. 4.The facility corporate management team will monitor and audit charts for proper documentation of death. 5.The facility or corporate Administration will monitor, as needed (upon death) ongoing. 6.This deficiency to be corrected by: 09/27/2021.	

at 1:25 p.m., the Director of Nursing (DoN) indicated the Hospice nurse and facility QMAs were in the building when Resident F died. The resident had refused dialysis and all appointments prior to her death.

A Policy and Procedure for "Death" was provided by the DoN on 8/19/21 at 1:30 p.m. The policy indicated, but was not limited to, "Purpose: To assure compliance with the state and local laws. To assure the resident's wishes regarding death are followed within appropriate legal parameters...Procedure: 1. If a death occurs at the facility, the staff member should note the time of death and contact the Administrator. If the family is not present, the family will also be contacted...7. Document the resident's death in the progress notes with copy of body release form."

This state tag relates to Complaint IN00360290.

Based on record review and interview, the facility failed to ensure complete documentation of a resident's death was in the clinical record for 1 of 1 resident reviewed. (Resident F)

Findings include:

Resident F's record was reviewed on 8/19/21 at 11:00 a.m. Resident F had diagnoses

that included, but were not limited to, high blood pressure, diabetes mellitus, and end stage renal failure.

A "Provisional Notification of Death - Burial Transit Permit" indicated Resident F's death occurred on 7/10/21 at 6:13 p.m.

The progress notes in the clinical record lacked documentation of the resident's condition, vital signs and symptoms preceding death, and had no documentation of who was notified, and the time of death.

During an interview, on 8/19/21 at 1:25 p.m., the Director of Nursing (DoN) indicated the Hospice nurse and facility QMAs were in the building when Resident F died. The resident had refused dialysis and all appointments prior to her death.

A Policy and Procedure for "Death" was provided by the DoN on 8/19/21 at 1:30 p.m. The policy indicated, but was not limited to, "Purpose: To assure compliance with the state and local laws. To assure the resident's wishes regarding death are followed within appropriate legal parameters...Procedure: 1. If a death occurs at the facility, the staff member should note the time of death and contact the

	Administrator. If the family is not present, the family will also be contacted...7. Document the resident's death in the progress notes with copy of body release form." This state tag relates to Complaint IN00360290.			

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