| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING<br>B. WING | 07/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUBURN SENIOR LIVING, LLC | 1675 W SEVENTH STREET, AUBURN, , 46706 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES... | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION... | (X5) COMPLETION DATE |
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| R 0000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00462397 and IN00462762.<br><br>Complaint IN00462397 - State deficiencies related to the allegations are cited at R0240.<br><br>Complaint IN00462762 - State deficiencies related to the allegations are cited at R0240.<br><br>Survey date: July 14, 2025<br><br>Facility number: 014775<br><br>Residential Census: 81<br><br>This State Residential Finding is cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed July 15, 2025 | R 0000 | | |
| R 0240 | Health Services - Deficiency<br><br>410 IAC 16.2-5-4(d)<br><br>(d) Personal care, and assistance | R 0240 | **1. Corrective Action Taken for Resident Identified (Resident B):** | 07/29/2025 |

with activities of daily living, shall be provided based upon individual needs and preferences.

Based on interview and record review, the facility failed to ensure care was provided based on individual needs and service plans for 1 of 3 residents reviewed (Resident B).

Findings include:

A report, dated 6/25/25, indicated Resident B had been sent to the hospital for symptoms of nausea, vomiting and malaise. At the hospital, Resident B was observed wearing 6 transdermal patches containing Rivastigmine 9.5 milligrams (mg)/24HR.

On 7/14/25 at 11:45 A.M., Resident B's record was reviewed. Diagnoses included dementia, orthostatic hypotension (low blood pressure when standing up from sitting or lying down position) and repeated falls. Resident B had recently returned to the facility, following hospitalization, on 6/19/25.

A service plan, dated 1/12/25, indicated Resident B required medication administration to be completed by staff due to confusion/cognitive loss. The goal was for staff to support the resident in taking all his medications safely and as

- Resident B's service plan was immediately reviewed and updated to reflect current needs and medication requirements.
- Resident B to return to facility on 7/29/2025, the care team is prepared to implement all updated service plan elements upon return.

**2. Identification of Other Residents Potentially Affected:**

- All current residents' service plans were audited to ensure that identified care and medication needs are being met and medications are in-house and available.
- All current residents

ordered by the physician.

1. A physician order, dated 1/12/25, was for Rivastigmine (Exelon) Transdermal patch 24 hour 9.5 milligrams (mg)/24HR-apply 1 patch transdermally 1 time per day for memory. Apply patch to clean, dry skin; remove old patch prior to placing new one.

A Medication Administration Record (MAR), dated June 2025, indicated Rivastigmine Transdermal patch had been applied to Resident B's scapula, alternating sides each day, on 6/20, 6/21, 6/22, 6/23, and 6/24/25.

A progress note, dated 6/24/25 at 6:38 p.m., indicated Resident B was observed vomiting, holding on to his abdomen and complaining of pain. The resident was sent to the hospital for evaluation and treatment.

A hospital note, dated 6/25/25 at unknown time, indicated Resident B presented to the ER with reports of increased falls. Upon arrival to the hospital, he was observed with multiple Rivastigmine Transdermal patches in place. 5 Rivastigmine Transdermal patches, with various prior dates, were removed from the residents skin.

Information for Rivastigmine Transdermal patch was

receiving
medication patches service plans and medication administration
reviewed.

**3. Systemic Changes Implemented to Prevent Recurrence:**

- A new medication availability
checklist has been implemented upon resident
admission/readmission and
with any new medication orders to ensure medications are in stock or
ordered promptly.
- All service plans will now be
reviewed and verified by the Wellness Director or designee within 24 hours of any hospital discharge, change in condition, or significant change in medications.
- Care staff and Med Techs were

retrieved from Drugs.com website on 7/14/25 at 1:00 P.M.. The website indicated Rivastigmine transdermal patches should be replaced every 24 hours; patients should be instructed to wear only 1 patch at a time; Signs of overdose with Rivastigmine include: severe nausea and vomiting, increasing muscle weakness, increased sweating and increased watering of the mouth.

2. A physician order, dated 6/20/25, indicated to give Magnesium Oxide oral tablet- 1 tablet by mouth 1 time per day for supplement.

A MAR, dated June 2025, indicated Magnesium Oxide was not available for administration on 6/20, 6/21, 6/22, 6/23, or 6/24/25.

Progress notes, dated 6/20-6/23/25, hadn't indicated Magnesium Oxide was not available for administration nor was there documentation of physician or family notification.

A medication administration note, dated 6/24/25 at 8:36 a.m., indicated the charge nurse and family were notified of need for Magnesium Oxide tablets.

A hospital note, dated 6/25/25 at an unknown time, indicated Resident B presented to the ER with reports of increased falls.

in-serviced on the importance of following individualized service plans and ensuring medication availability and administration aligns with documented care needs.

**4. Monitoring and Quality Assurance:**

- The Wellness Director or designee will audit 100% of all new admissions and readmissions for correct service plan implementation and medication availability for the next 60 days.
- A random weekly audit of 5 residents' service plans and medication availability and administration will be conducted for 90 days thereafter.

Lab work done in the ER, showed mostly stable labs but his magnesium blood level had been low and required replacement.

Information for Magnesium Oxide was retrieved from Drugs.com website on 7/14/25 at 2:00 P.M. The website indicated Magnesium Oxide was used as a supplement to maintain adequate magnesium in the body.

On 7/14/25 at 1:14 P.M., the Director of Nursing (DON) was interviewed. She indicated all staff who administer medications had been re-educated on application of Rivastigmine Transdermal patches and processes put in place to ensure the patches would be removed prior to placing a new one. The DON indicated she hadn't been aware of the Magnesium Oxide tablets not being given as ordered. She indicated nursing staff were to notify families, who supplied medications to their residents, when medications needed to be re-ordered. She indicated if the family wasn't able to provide the medication timely, it would be ordered from the facility pharmacy who provided emergency pharmacy services. Nursing staff were to notify the physician of delays in obtaining prescribed medications.

A current facility policy, titled "Transdermal Drug Delivery System (Patch) Application" was provided by the DON on 7/14/25 at 1:14 P.M., indicating a transdermal patch was to have the old patch removed prior to application of a new one and placement site of the new patch was to be documented on the MAR.

This Citation relates to Complaints IN00462397 and IN00462762.

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

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