

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/03/2025
NAME OF PROVIDER OR SUPPLIER AUBURN SENIOR LIVING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00452680. Complaint IN00452680 - State deficiencies related to the allegations are cited at R0006, R0036, and R0117. Survey date: March 3, 2025 Facility number: 014775 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed March 4, 2025	R 0000			
R 0006	Scope of Residential Care - Deficiency 410 IAC 16.2-5-0.5(f)(1-5) (f) The resident must be discharged if the resident:	R 0006	Corrective Action for Affected Resident(s): •The resident was provided access to a licensed provider through an emergency contractual agreement. •The resident's medical needs	04/04/2025	

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

(1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed contracted with a licensed provider for required comprehensive nursing care (Resident B). Findings include: On 3/3/25 at 11:12 A.M., Resident B's record was		were reassessed, and a care plan update was completed by a licensed provider. Systemic Changes: •A review of all residents requiring contracted licensed providers was conducted to ensure compliance. •The facility established a standing contract with an appropriate licensed provider network to prevent future deficiencies. •Staff was educated on policies regarding provider accessibility and contractual agreements. Monitoring and Compliance: •The Administrator or designee will audit provider assignments weekly for 60 days, then monthly for three months. •Results of audits will be reviewed during QAPI meetings for six months to ensure ongoing compliance.	
--	--	--	--

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

reviewed. Diagnoses included dementia and malignant melanoma of the scalp.

A Nurse Practitioner (NP) note, dated 1/23/25 at 1:23 p.m., indicated the resident had been visited after readmission to the facility following hospitalization and stay at a skilled nursing facility for rehabilitation. While hospitalized, a bleeding scalp lesion was biopsied and determined to be melanoma. The resident began palliative radiation. Additionally, he required follow up with nephrology due to indicators of kidney issues and struggled with edema requiring use of diuretics. The NP had a discussion with the home health services, scheduled to provide care to the resident upon readmission to the facility. The home health provider indicated the resident had not met criteria for home health due to requiring "total care". The NP notified the resident's Power of Attorney (POA) and his plan of care was to be determined.

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

An NP note, dated 2/13/25 at 4:31 p.m., indicated the resident had been to the emergency room, on 2/5/25, with complaints of cough and fatigue where he was found to be positive for influenza. The plan was for the resident to continue receiving palliative radiation to his dorsal head wound.

The NP note hadn't indicated there'd been any further discussion with family or facility staff regarding the resident's need for "total care" and care of his head wound.

Nurse Progress Notes indicated the following:

-1/27/25 at 1:16 p.m., treatment to resident's head was completed with no drainage to areas. The resident required maximal assistance of 2 for transfers and care.

-2/5/25 at 8:52 a.m., the family was notified and a message left regarding potential admission to hospice due to the resident having a decline. The note indicated home health services was to manage his malignant head wound.

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

-2/27/25 at 6:51 p.m., the resident went with family to see the oncologist to discuss future plans. The family had remained resistant to hospice care and the resident had been declined by home health services.

-3/1/25 at 1:11 p.m., treatment to skin cancer areas on top of the resident's head was completed. The old dressing was saturated with brown colored foul smelling drainage. A new clean dressing was applied.

A physician order, dated 1/23/25, was to wash the resident's posterior head tumor with baby soap and water/normal saline, separate cuticerin sheets/oil emulsion dressing, apply 1 sheet to scalp, cover with ABD pad and secure with a net, every day shift.

A Treatment Administration Record (TAR) dated February 2025, indicated by staff initials, the resident's dressing was completed by facility staff 2/2/25-2/5/25; 2/7/25-2/10/25; and 2/12/25-2/28/25. There was no documentation to indicate the dressing had been changes on 2/6, or 2/11/25.

On 3/3/25 at 12:00 P.M., the Executive Director (ED) and Resident Services Director (RSD) were interviewed. Both indicated it was the facility policy

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

the resident's requiring comprehensive nursing care must enter into a contract with a licensed provider to provide those services as the facility was not able to provide them. The ED indicated when the resident discharged from the skilled nursing facility back to the facility, staff were told by the skilled facility, home health services had been set up and his wound care would be provided by them. The RSD indicated upon learning the resident had been denied home health services, she had contacted the family to discuss alternatives such as admission to skilled nursing facility but the family declined.

A current "Assisted Living Admission Contract", signed by residents upon admission to the facility, was provided by the ED on 3/3/25 at 12:30 P.M. which stated: "Services (provided) included: room, 3 meals per day, weekly basic housekeeping services, weekly laundry, facility staffed 24 hours, and assistance with activities of daily living (eating, dressing, bathing, toileting, etc)...The Community will provide additional services (including but not limited to incontinence support, medication administration/management and care coordination) at the option and request of the Resident and/or Responsible Party...D.

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

Services Required for Continued Residency: The Resident and/or the Responsible Party understand that in order to meet the Community's residency requirement and continue residency in the Community, the Resident may require the assistance of additional services...The Community will reassess the resident's physical, cognitive, and psychosocial condition at least semi-annually and/or upon the identification of a significant change in condition. The Community shall notify the Resident and/or Responsible Party of any change in the services that the resident shall need in order to continue to meet the residency requirements. The Resident and/or Responsible Party agree to relocate the resident from the community...the resident has a condition for which the Community cannot provide care; the services at the Community are no longer adequate to meet the residents needs...."

This Citation relates to Complaint IN00452680.

Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed contracted with a licensed provider for required comprehensive nursing care (Resident B).

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

Findings include:

On 3/3/25 at 11:12 A.M., Resident B's record was reviewed. Diagnoses included dementia and malignant melanoma of the scalp.

A Nurse Practitioner (NP) note, dated 1/23/25 at 1:23 p.m., indicated the resident had been visited after readmission to the facility following hospitalization and stay at a skilled nursing facility for rehabilitation. While hospitalized, a bleeding scalp lesion was biopsied and determined to be melanoma. The resident began palliative radiation. Additionally, he required follow up with nephrology due to indicators of kidney issues and struggled with edema requiring use of diuretics. The NP had a discussion with the home health services, scheduled to provide care to the resident upon readmission to the facility. The home health provider indicated the resident had not met criteria for home health due to requiring "total care". The NP notified the resident's Power of Attorney (POA) and his plan of care was to be determined.

An NP note, dated 2/13/25 at 4:31 p.m., indicated the resident had been to the emergency room, on 2/5/25, with complaints of cough and fatigue where he was found to be positive for

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

influenza. The plan was for the resident to continue receiving palliative radiation to his dorsal head wound.

The NP note hadn't indicated there'd been any further discussion with family or facility staff regarding the resident's need for "total care" and care of his head wound.

Nurse Progress Notes indicated the following:

-1/27/25 at 1:16 p.m., treatment to resident's head was completed with no drainage to areas. The resident required maximal assistance of 2 for transfers and care.

-2/5/25 at 8:52 a.m., the family was notified and a message left regarding potential admission to hospice due to the resident having a decline. The note indicated home health services was to manage his malignant head wound.

-2/27/25 at 6:51 p.m., the resident went with family to see the oncologist to discuss future plans. The family had remained resistant to hospice care and the resident had been declined by home health services.

-3/1/25 at 1:11 p.m., treatment to skin cancer areas on top of the resident's head was completed. The old dressing was saturated with brown

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

colored foul smelling drainage. A new clean dressing was applied.

A physician order, dated 1/23/25, was to wash the resident's posterior head tumor with baby soap and water/normal saline, separate cuticerin sheets/oil emulsion dressing, apply 1 sheet to scalp, cover with ABD pad and secure with a net, every day shift.

A Treatment Administration Record (TAR) dated February 2025, indicated by staff initials, the resident's dressing was completed by facility staff 2/2/25-2/5/25; 2/7/25-2/10/25; and 2/12/25-2/28/25. There was no documentation to indicate the dressing had been changes on 2/6, or 2/11/25.

On 3/3/25 at 12:00 P.M., the Executive Director (ED) and Resident Services Director (RSD) were interviewed. Both indicated it was the facility policy the resident's requiring comprehensive nursing care must enter into a contract with a licensed provider to provide those services as the facility was not able to provide them. The ED indicated when the resident discharged from the skilled nursing facility back to the facility, staff were told by the skilled facility, home health services had been set up and his wound care would be

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

provided by them. The RSD indicated upon learning the resident had been denied home health services, she had contacted the family to discuss alternatives such as admission to skilled nursing facility but the family declined.

A current "Assisted Living Admission Contract", signed by residents upon admission to the facility, was provided by the ED on 3/3/25 at 12:30 P.M. which stated: "Services (provided) included: room, 3 meals per day, weekly basic housekeeping services, weekly laundry, facility staffed 24 hours, and assistance with activities of daily living (eating, dressing, bathing, toileting, etc)...The Community will provide additional services (including but not limited to incontinence support, medication administration/management and care coordination) at the option and request of the Resident and/or Responsible Party...D. Services Required for Continued Residency: The Resident and/or the Responsible Party understand that in order to meet the Community's residency requirement and continue residency in the Community, the Resident may require the assistance of additional services...The Community will reassess the resident's physical, cognitive, and psychosocial

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

	condition at least semi-annually and/or upon the identification of a significant change in condition. The Community shall notify the Resident and/or Responsible Party of any change in the services that the resident shall need in order to continue to meet the residency requirements. The Resident and/or Responsible Party agree to relocate the resident from the community...the resident has a condition for which the Community cannot provide care; the services at the Community are no longer adequate to meet the residents needs...." This Citation relates to Complaint IN00452680.			
R 0036	Residents' Rights- Deficiency 410 IAC 16.2-5-1.2(k)(1-2) (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.	R 0036	Corrective Action for Affected Resident(s): •For the cited resident, the physician was immediately notified of the resident's wound condition. •The resident's care plan was updated to reflect the physician's new orders and recommendations. Systemic Changes: •Nursing staff was re-educated on policies regarding physician notification for significant condition changes. •A review of all residents requiring MD notification was conducted to ensure compliance. •The facility revised documentation	04/04/2025

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

Based on interview and record review, the facility failed to ensure physician notification of a significant change in a resident's wound for 1 of 3 residents reviewed (Resident B).

Findings include:

On 3/3/25 at 11:12 A.M., Resident B's record was reviewed. Diagnoses included dementia and malignant melanoma of the scalp.

A Nurse Practitioner (NP) note, dated 1/23/25 at 1:23 p.m., indicated the resident had been visited following readmission to the facility following hospitalization and stay at a skilled nursing facility for rehabilitation. While hospitalized, a bleeding scalp lesion was biopsied and determined to be melanoma and he began palliative radiation.

A physician order, dated 1/23/25, was to wash the resident's posterior head tumor with baby soap and water/normal saline, separate cuticerin (type of dressing) sheets/oil emulsion dressing, apply 1 sheet to scalp, cover with ABD pad and secure with a net, every day shift.

Nurse Progress Notes indicated the following:

-1/27/25 at 1:16 p.m., treatment

procedures to ensure timely communication with providers.

- A physician notification checklist was implemented as part of the wound assessment process.

Monitoring and Compliance:

- The Director of Nursing (DON) or designee will audit wound documentation and physician notifications weekly for 60 days, then monthly for three months.

- Findings will be presented in QAPI meetings for six months to ensure sustained compliance.

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

to resident's head was completed with no drainage to areas. The resident required maximal assistance of 2 for transfers and care.

-3/1/25 at 1:11 p.m., the treatment to skin cancer areas on top of the resident's head was completed. The old dressing was saturated with brown colored foul smelling drainage. A new clean dressing was applied. There was no documentation the physician or a practitioner was notified.

There was no further documentation of the resident's wound such as appearance, size, color, drainage, odor, or pain after 1/27/25 until 3/1/25 when the wound dressing was discolored and foul smelling.

On 3/3/25 at 11:52 A.M., Licensed Practical Nurse 2 (LPN) was interviewed. LPN 2 indicated she had changed Resident B's dressing to his head wound on 3/1/25 and observed brown colored foul smelling drainage on his old dressing. When asked, she indicated she had notified the Resident Services Director (RSD) but couldn't recall if she'd notified the Nurse Practitioner (NP). She checked her secured text messages with the NP but couldn't find any notification.

On 3/3/25 at 12:00 P.M., the

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

RSD was interviewed. She indicated Resident B had visited the oncology doctor on 2/27/25 and there had been no indication, at the time, that his head wound appeared infected. She indicated there was always drainage from the wound however, staff were to notify the NP or physician of changes in a wound which could indicate infection (increased drainage, bloody or other types of exudate, odor) and need for treatment.

"Wound Care" (2019) was retrieved on 3/3/25 from the National Library of Medicine website [ncbi.nlm.nih.gov](https://www.ncbi.nlm.nih.gov). The article indicated: "A break in the skin allows bacteria to enter and begin to multiply. Contamination of wounds can progress from localized infection to systemic infection, sepsis, and subsequent life-and limb-threatening infection. Signs of localized wound infection include redness, warmth, and tenderness around the wound. Purulent or malodorous drainage may also be present...."

A current facility policy, titled "Change in Condition", was provided by the RSD on 3/3/25 at 12:40 P.M., and indicated: "When a resident exhibits a change in condition, caregivers should notify the nurse and Resident Services Director...If

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

there is an actual change in condition the resident's physician is notified...."

This Citation relates to Complaint IN00452680.

Based on interview and record review, the facility failed to ensure physician notification of a significant change in a resident's wound for 1 of 3 residents reviewed (Resident B).

Findings include:

On 3/3/25 at 11:12 A.M., Resident B's record was reviewed. Diagnoses included dementia and malignant melanoma of the scalp.

A Nurse Practitioner (NP) note, dated 1/23/25 at 1:23 p.m., indicated the resident had been visited following readmission to the facility following hospitalization and stay at a skilled nursing facility for rehabilitation. While hospitalized, a bleeding scalp lesion was biopsied and determined to be melanoma and he began palliative radiation.

A physician order, dated 1/23/25, was to wash the resident's posterior head tumor with baby soap and water/normal saline, separate cuticerin (type of dressing) sheets/oil emulsion dressing, apply 1 sheet to scalp, cover

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

with ABD pad and secure with a net, every day shift.

Nurse Progress Notes indicated the following:

-1/27/25 at 1:16 p.m., treatment to resident's head was completed with no drainage to areas. The resident required maximal assistance of 2 for transfers and care.

-3/1/25 at 1:11 p.m., the treatment to skin cancer areas on top of the resident's head was completed. The old dressing was saturated with brown colored foul smelling drainage. A new clean dressing was applied. There was no documentation the physician or a practitioner was notified.

There was no further documentation of the resident's wound such as appearance, size, color, drainage, odor, or pain after 1/27/25 until 3/1/25 when the wound dressing was discolored and foul smelling.

On 3/3/25 at 11:52 A.M., Licensed Practical Nurse 2 (LPN) was interviewed. LPN 2 indicated she had changed Resident B's dressing to his head wound on 3/1/25 and observed brown colored foul smelling drainage on his old dressing. When asked, she indicated she had notified the Resident Services Director (RSD) but couldn't recall if she'd

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

notified the Nurse Practitioner (NP). She checked her secured text messages with the NP but couldn't find any notification.

On 3/3/25 at 12:00 P.M., the RSD was interviewed. She indicated Resident B had visited the oncology doctor on 2/27/25 and there had been no indication, at the time, that his head wound appeared infected. She indicated there was always drainage from the wound however, staff were to notify the NP or physician of changes in a wound which could indicate infection (increased drainage, bloody or other types of exudate, odor) and need for treatment.

"Wound Care" (2019) was retrieved on 3/3/25 from the National Library of Medicine website [ncbi.nlm.nih.gov](https://www.ncbi.nlm.nih.gov). The article indicated: "A break in the skin allows bacteria to enter and begin to multiply. Contamination of wounds can progress from localized infection to systemic infection, sepsis, and subsequent life-and limb-threatening infection. Signs of localized wound infection include redness, warmth, and tenderness around the wound. Purulent or malodorous drainage may also be present...."

A current facility policy, titled "Change in Condition", was

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

	provided by the RSD on 3/3/25 at 12:40 P.M., and indicated: "When a resident exhibits a change in condition, caregivers should notify the nurse and Resident Services Director...If there is an actual change in condition the resident's physician is notified...." This Citation relates to Complaint IN00452680.			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty	R 0117	Corrective Action for Affected Resident(s): •Staff involved in the incident were immediately re-educated on their scope of practice. •Resident(s) affected were reassessed by appropriately licensed personnel, and care plans were adjusted accordingly. Systemic Changes: •A mandatory competency check for all staff regarding scope of practice was conducted. •Policies and procedures related to staff responsibilities were reviewed and updated. •The facility implemented quarterly refresher training on state and federal regulations regarding scope of practice. Monitoring and Compliance:	04/04/2025

(50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.

Based on interview and record review, the facility failed to ensure staff performed duties within their scope of practice for 1 of 3 residents reviewed (Resident B).

Findings include:

On 3/3/25 at 11:12 A.M., Resident B's record was reviewed. Diagnoses included dementia and malignant melanoma of the scalp being treated with palliative radiation.

A physician order, dated 1/23/25, was to wash the resident's posterior head tumor with baby soap and water/normal saline, separate cuticerin (typr pf dressing) sheets/oil emulsion dressing, apply 1 sheet to scalp, cover with ABD pad and secure with a net, every day shift.

A Treatment Administration Record (TAR) dated February 2025, indicated by staff initials, Qualified Medication Aides (QMA) administered treatment to the resident's head tumor as ordered on 2/5/25, 2/7, 2/9, 2/13, 2/14, 2/18, 2/20-2/23, and 2/25-2/28/25. QMA 3 provided 12 treatments, QMA 4 provided

•The Administrator or designee will conduct random audits of staff performance weekly for 60 days, then monthly for three months.

•Staff compliance will be reviewed during QAPI meetings for six months.

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

1, and QMA 5 provided 1 treatment.

On 3/3/25 at 12:00 P.M., the Resident Services Director (RSD) was interviewed. She indicated a licensed nurse should've provided the dressing changes to Resident B's head tumor. She indicated schanging dressings was outside of a QMA's scope of practice. She indicated it was possible, the QMA's may have signed their initials even when/if the nurse completed the treatment but theyshouldn't have initialed anything they did not complete.

Scope of Practice for Qualified Medication Aide, dated 11/2007 by the Indiana Department of Health states: The following are within the scope of practice for the QMA unless prohibited by facility policy: (3) Administer regularly prescribed medication which the QMA has been trained to administer only after personally preparing the medication to be administered. The QMA shall document in a resident's clinical record all medications that the QMA personally administered. The QMA shall not document in a resident's record any medications that was administered by another person or not administered at all...(12) Apply topical medication to minor skin conditions such as dermatitis, scabies, pediculosis,

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

FORM APPROVED

OMB NO. 0938-0391

fungal-infection, psoriasis, eczema, first degree burn, or stage 1 decubitus ulcer (skin not broken)...(16) Apply a dressing to a minor skin tear that has been assessed by a licensed nurse...The following tasks shall NOT be included in the QMA scope of practice: (6) Administer a treatment that involves advanced skin conditions, including stage II, III, and IV decubitus ulcers".

A position description for Qualified Medication Aide was provided on 3/3/25 at 1:52 P.M. by the Business Office Manager which indicated the following: "The QMA is under the direction of the Licensed Nurse and is delegated the responsibility to administer medications in accordance with federal and state regulations and according to the Indiana State Department of Health...Specific Tasks/Duties...3. Completes and performs all treatments according to policy standards and physician order...c. Apply a dressing to a minor skin tear...J. Apply treatments to minor skin conditions as ordered-stage I areas; skin conditions i.e., fungal infections, psoriasis, eczema, etc...."

This Citation relates to Complaint IN00452680.

Based on interview and record review, the facility failed to

ensure staff performed duties within their scope of practice for 1 of 3 residents reviewed (Resident B).

Findings include:

On 3/3/25 at 11:12 A.M., Resident B's record was reviewed. Diagnoses included dementia and malignant melanoma of the scalp being treated with palliative radiation.

A physician order, dated 1/23/25, was to wash the resident's posterior head tumor with baby soap and water/normal saline, separate cuticerin (typr pf dressing) sheets/oil emulsion dressing, apply 1 sheet to scalp, cover with ABD pad and secure with a net, every day shift.

A Treatment Administration Record (TAR) dated February 2025, indicated by staff initials, Qualified Medication Aides (QMA) administered treatment to the resident's head tumor as ordered on 2/5/25, 2/7, 2/9, 2/13, 2/14, 2/18, 2/20-2/23, and 2/25-2/28/25. QMA 3 provided 12 treatments, QMA 4 provided 1, and QMA 5 provided 1 treatment.

On 3/3/25 at 12:00 P.M., the Resident Services Director (RSD) was interviewed. She indicated a licensed nurse should've provided the dressing changes to Resident B's head

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

FORM APPROVED

OMB NO. 0938-0391

tumor. She indicated schanging dressings was outside of a QMA's scope of practice. She indicated it was possible, the QMA's may have signed their initials even when/if the nurse completed the treatment but theyshouldn't have initialed anything they did not complete.

Scope of Practice for Qualified Medication Aide, dated 11/2007 by the Indiana Department of Health states: The following are within the scope of practice for the QMA unless prohibited by facility policy: (3) Administer regularly prescribed medication which the QMA has been trained to administer only after personally preparing the medication to be administered. The QMA shall document in a resident's clinical record all medications that the QMA personally administered. The QMA shall not document in a resident's record any medications that was administered by another person or not administered at all...(12) Apply topical medication to minor skin conditions such as dermatitis, scabies, pediculosis, fungal-infection, psoriasis, eczema, first degree burn, or stage 1 decubitus ulcer (skin not broken)...(16) Apply a dressing to a minor skin tear that has been assessed by a licensed nurse...The following tasks shall NOT be included in the QMA scope of practice: (6) Administer

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

a treatment that involves advanced skin conditions, including stage II, III, and IV decubitus ulcers".

A position description for Qualified Medication Aide was provided on 3/3/25 at 1:52 P.M. by the Business Office Manager which indicated the following:
"The QMA is under the direction of the Licensed Nurse and is delegated the responsibility to administer medications in accordance with federal and state regulations and according to the Indiana State Department of Health...Specific Tasks/Duties...3. Completes and performs all treatments according to policy standards and physician order...c. Apply a dressing to a minor skin tear...J. Apply treatments to minor skin conditions as ordered-stage I areas; skin conditions i.e., fungal infections, psoriasis, eczema, etc...."

This Citation relates to Complaint IN00452680.

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