STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MEADOWS SENIOR ASSISTED LIVING	11570 E 126TH STREET, FISHERS, , 46037

(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 IN00365827. Complaint IN00365827 - Substantiated. State deficiencies related to the allegations are cited at R240. Survey date: November 5, 2021 Facility number: 14910 Residential Census: 109 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on November 9, 2021	R 0000	Please accept the attached plan of correction as credible allegation of compliance to the deficiency cited during the Investigation of Complaint conducted on November 5, 2021. Hopefully, you will find the remedies are sufficient, thoroughly explained, and able to provide a clear picture of how we corrected the concern. We would like to formally request your consideration for granting this community paper compliance.	
R 0240	Health Services - Deficiency 410 IAC 16.2-5-4(d) (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.	R 0240	It is the policy of Priority Life Care to provide personal care and assistance with activities of daily living, based upon individual needs and preferences. The deficient practice was corrected	12/10/2021

	2. The clinical record for Resident C was reviewed on 11/5/21 at 11:32 a.m. The diagnoses included, but were not limited to, chronic pain. The 9/17/21 pain assessment indicated she had pain in her front, lower legs, and her current pain was rated a 5 out of 10 on the pain scale. Repositioning, rest, and medication, made the pain better. Repositioning and resting were "helpful" and medication was "very helpful." The physician's orders indicated to apply a Fentanyl patch every 3 days for pain from 7/16/21 through 10/21/21, and then every 2 days beginning 10/22/21. The orders indicated for a 15 mg Oxycodone tablet to be administered 3 times a day, beginning 6/18/21. The October and November, 2021 MARs (medication administration records) indicated a Fentanyl patch was applied on the following dates: 10/2/21, 10/5/21, 10/8/21, 10/11/21, 10/17/21, 10/20/21, 10/22/21, 10/23/21, 10/25/21, 10/27/21, 10/31/21, and 11/4/21. The MARs indicated the Fentanyl patch was unavailable on 10/14/21 and were blank on 10/29/21 and 11/2/21. They indicated the Oxycodone was unavailable for 17 scheduled administrations		immediately upon identification. The staff member involved was immediately re-educated. All residents had the potential to be affected by the deficient practice. As a preventive measure, nursing staff will be re-educated on medication administration policy and procedure by December 10, 2021. The DON, or her designee, will audit clinical records and conduct observations of medication passes daily for 7 days, weekly for 4 weeks and as required by policy, or as needed thereafter, to ensure compliance. Any concerns will be documented and presented to the Quality Assurance Committee for resolution. All systemic changes will be completed by December 10, 2021.	

and was blank for 16 scheduled administrations.

The 10/21/21, 10/23/21, and 10/24/21 progress notes indicated the Oxycodone was not available.

An interview and observation was conducted with QMA (Qualified Medication Aide) 3 and Resident C on 11/5/21 at 12:50 p.m. Resident C's Fentanyl patch was on her back, just below her right shoulder. Resident C indicated there was one time the facility did not apply her patch. QMA 3 indicated it was because they ran out of her Fentanyl patch prescription, so she went without her Fentanyl patch for about a week, roughly a month ago. QMA 3 indicated the blanks on the MAR for her Oxycodone were "probably right. She runs out of her Oxy [Oxycodone] all the time."

An interview was conducted with the AED (Assistant Executive Director) on 11/5/21 at 1:41 p.m. She indicated there was a time Resident C did not get her Fentanyl patch, a couple weeks ago, as they'd had issues with their pharmacy lately.

An interview was conducted with NP (Nurse Practitioner) 2 on 11/5/21 at 2:39 p.m. She indicated Resident C's daughter had informed her she missed

her Fentanyl patch for a week in October, 2021. She may have needed a refill. She could not recall the facility informing her about the Oxycodone not being available, but it made sense, when reviewing her prescription refill orders, because her refill dates went from 10/5/21 until 10/27/21, but she needed a refill every 15 days.

A Resident Medication Administration policy was received on 11/5/21 at 10:50 a.m. from AED. It indicated, "Policy To ensure that medications are administered to resident in accordance to prescribed schedule...Procedure...If medication is not available, the qualified staff will notify the Licensed Nurse. The Licensed Nurse will notify the Pharmacy for medication order and request estimated delivery time. If a dose of medication is missed related to no supply and/or unavailable in the Emergency Drug Kit the Licensed Nurse will notify the Provider and Family, when acceptable, of reason related to the missed dose. The Licensed Nurse will then document conversations in the clinical record."

This State tag relates to Complaint IN00365827.

Based on interview and record

review, the facility failed to administer pain medications as ordered for 2 of 3 residents reviewed for pain (Residents B and C) and failed to administer medication appropriately for 1 of 1 residents during a random observation. (Resident B)

Findings include:

1. a. The clinical record for Resident B was reviewed on 11/5/21 at 11:32 a.m. Resident B's diagnoses included, but not limited to, Crohn's disease, anxiety disorder, fibromyalgia, osteoarthritis, and bursitis of shoulder.

The RDCO (Regional Director of Clinical Operations) was unable to locate any pain assessments for Resident B in the clinical record on 11/5/21 at 2:34 p.m.

A physician's order dated 7/23/21, indicated, to apply one Fentanyl (pain medication) 100 mcg(micrograms) patch transdermally (on skin) every 3 days for chronic pain. This order was discontinued on 10/15/21 and renewed on 10/16/21.

A physician's order dated 7/23/21, indicated, to apply one Fentanyl 25 mcg patch transdermally every 3 days for chronic pain. This order was discontinued on 10/15/21 and renewed on 10/16/21.

A physician's order dated

7/15/21, indicated, to give one 7.5-325 mg hydrocodone-acetaminophen (Norco) tablet five times a day for chronic pain.

An interview with Resident B was conducted on 11/5/21 at 1 p.m. She indicated, the facility was always running out of her pain medications and sometimes had to wait for days for it. She stated, she had experienced withdrawal like symptoms such as restless leg movements, itchiness, and difficulty sleeping during the times when her pain medication was not available.

Resident B's MAR (medication administration record) for October was received on 11/5/21 at 2:34 p.m. from AED (Assistant Executive Director). The MAR indicated, the 100 mcg Fentanyl patch was administered on the following days:

10/3/21

10/6/21

10/16/21

10/19/21

10/22/21

10/28/21

10/31/21

Resident B's MAR for October received on 11/5/21 at 2:34 p.m. indicated, the 25 mcg Fentanyl patch was administered on the following days:

10/3/21

10/6/21

10/16/21

10/19/21

10/22/21

10/28/21

10/31/21

Resident B's Fentanyl patches were not administered every 3 days as ordered. According to the MAR, Resident B missed her Fentanyl doses on:

10/9/21

10/12/21

10/15/21--was later administered on 10/16/21

10/25/21

Resident B's MAR for October and November received on 11/5/21 at 2:34 p.m. indicated, Resident B did not receive the Norco tablet as ordered on the following dates and times:

10/1/21 9 a.m. and 5 p.m.

10/7/21 5 a.m. and 10 p.m.

10/8/21 1 p.m.

10/9/21 10 p.m.

10/15/21 1 p.m.

10/16/21 10 p.m.

10/17/21 5 a.m.

10/19/21 10 p.m.

10/21/21 10 p.m.

10/31/21 10 p.m.

11/1/21 1 p.m. and 10 p.m.

11/2/21 5 a.m., 1 p.m., 5 p.m., and 10 p.m.

11/4/21 5 p.m. and 10 p.m.

An interview with the facility's Pharmacy was conducted on 11/5/21 at 2:26 p.m. They indicated fentanyl patches were ordered twice in the month of October 2021. Once on 10/10/21 and again on 10/25/21. They stated both times the Fentanyl patches were ordered, they were delivered on the same day.

An interview was conducted with Resident B's Nurse Practioner (NP) on 11/5/21 at 2:44 p.m. She indicated, she was not aware that Resident B had gone a few days without her Fentanyl patch.

b. An observation was made on 11/5/21 at 1:09 p.m. of Resident B receiving medications. QMA(Qualified Medication Assistant) 4 walked into Resident B's room with a paper medication cup which contained unidentified medications mixed in with pudding. QMA 4 handed the medication cup to Resident B and immediately left the room. Resident B had not yet taken a bite of the medication/pudding mixture.

An interview with QMA 4 was conducted on 11/5/21 at 1:12 p.m. She indicated, she should not have left Resident B's room without witnessing if Resident B ingested the medication.

2. The clinical record for Resident C was reviewed on 11/5/21 at 11:32 a.m. The diagnoses included, but were not limited to, chronic pain.

The 9/17/21 pain assessment indicated she had pain in her front, lower legs, and her current pain was rated a 5 out of 10 on the pain scale. Repositioning, rest, and medication, made the pain better. Repositioning and resting were "helpful" and medication was "very helpful."

The physician's orders indicated to apply a Fentanyl patch every 3 days for pain from 7/16/21 through 10/21/21, and then every 2 days beginning

10/22/21. The orders indicated for a 15 mg Oxycodone tablet to be administered 3 times a day, beginning 6/18/21.

The October and November, 2021 MARs (medication administration records) indicated a Fentanyl patch was applied on the following dates: 10/2/21, 10/5/21, 10/8/21, 10/11/21, 10/17/21, 10/20/21, 10/22/21, 10/23/21, 10/25/21, 10/27/21, 10/31/21, and 11/4/21. The MARs indicated the Fentanyl patch was unavailable on 10/14/21 and were blank on 10/29/21 and 11/2/21. They indicated the Oxycodone was unavailable for 17 scheduled administrations and was blank for 16 scheduled administrations.

The 10/21/21, 10/23/21, and 10/24/21 progress notes indicated the Oxycodone was not available.

An interview and observation was conducted with QMA (Qualified Medication Aide) 3 and Resident C on 11/5/21 at 12:50 p.m. Resident C's Fentanyl patch was on her back, just below her right shoulder. Resident C indicated there was one time the facility did not apply her patch. QMA 3 indicated it was because they ran out of her Fentanyl patch prescription, so she went without her Fentanyl patch for

about a week, roughly a month ago. QMA 3 indicated the blanks on the MAR for her Oxycodone were "probably right. She runs out of her Oxy [Oxycodone] all the time."

An interview was conducted with the AED (Assistant Executive Director) on 11/5/21 at 1:41 p.m. She indicated there was a time Resident C did not get her Fentanyl patch, a couple weeks ago, as they'd had issues with their pharmacy lately.

An interview was conducted with NP (Nurse Practitioner) 2 on 11/5/21 at 2:39 p.m. She indicated Resident C's daughter had informed her she missed her Fentanyl patch for a week in October, 2021. She may have needed a refill. She could not recall the facility informing her about the Oxycodone not being available, but it made sense, when reviewing her prescription refill orders, because her refill dates went from 10/5/21 until 10/27/21, but she needed a refill every 15 days.

A Resident Medication Administration policy was received on 11/5/21 at 10:50 a.m. from AED. It indicated, "Policy To ensure that medications are administered to resident in accordance to prescribed schedule...Procedure...If medication is not available, the

qualified staff will notify the Licensed Nurse. The Licensed Nurse will notify the Pharmacy for medication order and request estimated delivery time. If a dose of medication is missed related to no supply and/or unavailable in the Emergency Drug Kit the Licensed Nurse will notify the Provider and Family, when acceptable, of reason related to the missed dose. The Licensed Nurse will then document conversations in the clinical record."

This State tag relates to Complaint IN00365827.

Based on interview and record review, the facility failed to administer pain medications as ordered for 2 of 3 residents reviewed for pain (Residents B and C) and failed to administer medication appropriately for 1 of 1 residents during a random observation. (Resident B)

Findings include:

1. a. The clinical record for Resident B was reviewed on 11/5/21 at 11:32 a.m. Resident B's diagnoses included, but not limited to, Crohn's disease, anxiety disorder, fibromyalgia, osteoarthritis, and bursitis of shoulder.

The RDCO (Regional Director of Clinical Operations) was unable to locate any pain assessments

for Resident B in the clinical record on 11/5/21 at 2:34 p.m.

A physician's order dated 7/23/21, indicated, to apply one Fentanyl (pain medication) 100 mcg(micrograms) patch transdermally (on skin) every 3 days for chronic pain. This order was discontinued on 10/15/21 and renewed on 10/16/21.

A physician's order dated 7/23/21, indicated, to apply one Fentanyl 25 mcg patch transdermally every 3 days for chronic pain. This order was discontinued on 10/15/21 and renewed on 10/16/21.

A physician's order dated 7/15/21, indicated, to give one 7.5-325 mg hydrocodone-acetaminophen (Norco) tablet five times a day for chronic pain.

An interview with Resident B was conducted on 11/5/21 at 1 p.m. She indicated, the facility was always running out of her pain medications and sometimes had to wait for days for it. She stated, she had experienced withdrawal like symptoms such as restless leg movements, itchiness, and difficulty sleeping during the times when her pain medication was not available.

Resident B's MAR (medication administration record) for October was received on

11/5/21 at 2:34 p.m. from AED (Assistant Executive Director). The MAR indicated, the 100 mcg Fentanyl patch was administered on the following days:

10/3/21

10/6/21

10/16/21

10/19/21

10/22/21

10/28/21

10/31/21

Resident B's MAR for October received on 11/5/21 at 2:34 p.m. indicated, the 25 mcg Fentanyl patch was administered on the following days:

10/3/21

10/6/21

10/16/21

10/19/21

10/22/21

10/28/21

10/31/21

Resident B's Fentanyl patches were not administered every 3 days as ordered. According to the MAR, Resident B missed

her Fentanyl doses on:

10/9/21

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Resident B's MAR for October and November received on 11/5/21 at 2:34 p.m. indicated, Resident B did not receive the Norco tablet as ordered on the following dates and times:

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11/2/21 5 a.m., 1 p.m., 5 p.m., and 10 p.m.

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2. The clinical record for

	Resident C was reviewed on 11/5/21 at 11:32 a.m. The diagnoses included, but were not limited to, chronic pain. The 9/17/21 pain assessment indicated she had pain in her front, lower legs, and her current pain was rated a 5 out of 10 on the pain scale. Repositioning, rest, and medication, made the pain better. Repositioning and resting were "helpful" and medication was "very helpful." The physician's orders indicated to apply a Fentanyl patch every 3 days for pain from 7/16/21 through 10/21/21, and then every 2 days beginning 10/22/21. The orders indicated for a 15 mg Oxycodone tablet to be administered 3 times a day, beginning 6/18/21.			

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The 10/21/21, 10/23/21, and 10/24/21 progress notes indicated the Oxycodone was not available.

An interview and observation was conducted with QMA (Qualified Medication Aide) 3 and Resident C on 11/5/21 at 12:50 p.m. Resident C's Fentanyl patch was on her back, just below her right shoulder. Resident C indicated there was one time the facility did not apply her patch. QMA 3 indicated it was because they ran out of her Fentanyl patch prescription, so she went without her Fentanyl patch for about a week, roughly a month ago. QMA 3 indicated the blanks on the MAR for her Oxycodone were "probably right. She runs out of her Oxy

[Oxycodone] all the time."

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If a dose of medication is missed related to no supply and/or unavailable in the Emergency Drug Kit the Licensed Nurse will notify the Provider and Family, when acceptable, of reason related to the missed dose. The Licensed Nurse will then document conversations in the clinical record."

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Based on interview and record review, the facility failed to administer pain medications as ordered for 2 of 3 residents reviewed for pain (Residents B and C) and failed to administer medication appropriately for 1 of 1 residents during a random observation. (Resident B)

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An interview with Resident B was conducted on 11/5/21 at 1 p.m. She indicated, the facility was always running out of her pain medications and sometimes had to wait for days for it. She stated, she had experienced withdrawal like symptoms such as restless leg movements, itchiness, and difficulty sleeping during the times when her pain medication was not available.

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administered on the following days:

10/3/21

10/6/21

10/16/21

10/19/21

10/22/21

10/28/21

10/31/21

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10/3/21

10/6/21

10/16/21

10/19/21

10/22/21

10/28/21

10/31/21

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10/8/21 1 p.m.

10/9/21 10 p.m.

10/15/21 1 p.m.

10/16/21 10 p.m.

10/17/21 5 a.m.

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A physician's order dated 7/23/21, indicated, to apply one Fentanyl 25 mcg patch transdermally every 3 days for chronic pain. This order was discontinued on 10/15/21 and renewed on 10/16/21.

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10/6/21

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10/28/21

10/31/21

Resident B's MAR for October received on 11/5/21 at 2:34 p.m. indicated, the 25 mcg Fentanyl

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10/3/21

10/6/21

10/16/21

10/19/21

10/22/21

10/28/21

10/31/21

Resident B's Fentanyl patches were not administered every 3 days as ordered. According to the MAR, Resident B missed her Fentanyl doses on:

10/9/21

10/12/21

10/15/21--was later administered on 10/16/21

10/25/21

Resident B's MAR for October and November received on 11/5/21 at 2:34 p.m. indicated, Resident B did not receive the Norco tablet as ordered on the following dates and times:

10/1/21 9 a.m. and 5 p.m.

10/7/21 5 a.m. and 10 p.m.

10/8/21 1 p.m.

	10/9/21 10 p.m. 10/15/21 1 p.m. 10/16/21 10 p.m. 10/17/21 5 a.m. 10/19/21 10 p.m. 10/21/21 10 p.m. 10/31/21 10 p.m. 11/1/21 1 p.m. and 10 p.m. 11/2/21 5 a.m., 1 p.m., 5 p.m., and 10 p.m. 11/4/21 5 p.m. and 10 p.m. An interview with the facility's Pharmacy was conducted on 11/5/21 at 2:26 p.m. They indicated fentanyl patches were ordered twice in the month of October 2021. Once on 10/10/21 and again on 10/25/21. They stated both times the Fentanyl patches were ordered, they were delivered on the same day. An interview was conducted with Resident B's Nurse Practioner (NP) on 11/5/21 at 2:44 p.m. She indicated, she was not aware that Resident B had gone a few days without her Fentanyl patch. b. An observation was made on 11/5/21 at 1:09 p.m. of Resident B receiving medications.			

	QMA(Qualified Medication Assistant) 4 walked into Resident B's room with a paper medication cup which contained unidentified medications mixed in with pudding. QMA 4 handed the medication cup to Resident B and immediately left the room. Resident B had not yet taken a bite of the medication/pudding mixture. An interview with QMA 4 was conducted on 11/5/21 at 1:12 p.m. She indicated, she should not have left Resident B's room without witnessing if Resident B ingested the medication.			

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