

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 09/20/2024	
NAME OF PROVIDER OR SUPPLIER VITA OF MARION		STREET ADDRESS, CITY, STATE, ZIP CODE 4211 S ADAMS STREET, MARION, , 46953					
(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 Complaints IN00442720, IN00443030, IN00443300, and IN00443655. Complaint IN00442720 - State deficiencies related to the allegations are cited at R0036. Complaint IN00443300 - State deficiencies related to the allegations are cited at R0052. Complaint IN00443655 - State deficiencies related to the allegations are cited at R0297. Complaint IN00443030 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey date: September 20, 2024 Facility number: 015081 Residential Census: 68 These State Residential	R 0000					

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	Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed September 30, 2024.			
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. Based on record review and interview, the facility failed to notify the resident representative and physician when a resident experienced a significant change in condition requiring a transfer to the hospital for 1 of 4 residents reviewed. (Resident B) Finding includes: During an interview, on 9/20/24 at 11:42 a.m., Resident B's representative indicated the facility failed to notify the representative when the	R 0036	<u>1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Families and Primary Care Providers notified for Resident B.</u> <u>2</u> <u>.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u> All residents that have had a change of condition have the potential to be affected by the deficient practice. Incidents and transfers for last 30 days reviewed to ensure notifications have been completed. 3 Nursing staff in- serviced 10.9.2024 on Notification of Family/ Primary Care Provider for change of condition by Director of Nursing. Director of Nursing and/or	10/20/2024

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resident was sent to the hospital because of behaviors on 9/5/24. Resident B's clinical record was reviewed on 9/20/24 at 1:26 p.m. Diagnoses included dementia, moderate, with behavioral disturbance, major depressive disorder, recurrent, and anxiety disorder. Physician's orders included memantine (for Alzheimer's disease) 10 mg (milligrams) daily (6/3/23), donepezil (for Alzheimer's disease) 10 mg daily (6/3/23), buspirone (anti-anxiety) 10 mg three times a day, and quetiapine (antipsychotic) 25 mg daily (8/23/24) and 150 mg at bedtime (9/9/24). A Behavior Note, dated 9/5/24 at 3:30 a.m., indicated Resident B woke up and said she was smelling chemicals in her room, and they had gotten all over her. The resident was assisted back to her room. After she received assistance with cleaning up and changing her clothes, she began coughing and yelling in the hallway. She said she needed some fresh air. The resident yelled, cussed, and spit at the staff. The resident calmed down, and the nurse was notified. A Behavior Note, dated 9/5/24 at 5:33 p.m., indicated emergency services were called		designee to audit shift to shift report for change in condition and documentation of family/ Primary Care provider notification. Audit will be completed 3 times a week for 4 weeks, 1 time a week for 3 months. 4 Audits will be reviewed in monthly QA meetings for 6 months. QA committee to make recommendations on the need for ongoing audits. 5 Compliance date 10/20/24	
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for assistance with the resident for behaviors that were unable to be redirected by staff.

The Progress Notes lacked notification of the medical provider, the DON, or the resident representative.

A Progress Note, dated 9/5/24 at 8:25 p.m., indicated the resident returned from the hospital via a private vehicle accompanied by her family.

During an interview, on 9/20/24 at 3:03 p.m., the DON indicated she had no additional information regarding Resident B's transfer to the hospital on 9/5/24.

During an interview, on 9/20/24 at 4:45 p.m., the Administrator indicated when a resident was transferred to the hospital, the family, the physician, and the DON should be notified.

During an interview, on 9/20/24 at 4:46 p.m., the DON indicated the notifications should be documented in the resident's clinical record.

A facility policy, last revised 4/23/24 and provided by the Administrator on 9/20/24 at 12:18 p.m., titled "Notification of Changes in Resident Status," indicated "... A. The Administrator or the Director of Nursing or designee will notify the Resident's provider when a

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change in a resident's mental or physical status is observed by staff. Reporting will be within 24 hours after the observation. Serious or life-threatening situation should be reported to the provider immediately after activating the Emergency Management Services (911). B. The Administrator or the Director of Nursing or designee will notify the resident representative when a resident's accident/incident requires transfer out to the community"

This citation relates to Complaint IN00442720.

Based on record review and interview, the facility failed to notify the resident representative and physician when a resident experienced a significant change in condition requiring a transfer to the hospital for 1 of 4 residents reviewed. (Resident B)

Finding includes:

During an interview, on 9/20/24 at 11:42 a.m., Resident B's representative indicated the facility failed to notify the representative when the resident was sent to the hospital because of behaviors on 9/5/24.

Resident B's clinical record was reviewed on 9/20/24 at 1:26 p.m. Diagnoses included dementia, moderate, with

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behavioral disturbance, major depressive disorder, recurrent, and anxiety disorder.

Physician's orders included memantine (for Alzheimer's disease) 10 mg (milligrams) daily (6/3/23), donepezil (for Alzheimer's disease) 10 mg daily (6/3/23), buspirone (anti-anxiety) 10 mg three times a day, and quetiapine (antipsychotic) 25 mg daily (8/23/24) and 150 mg at bedtime (9/9/24).

A Behavior Note, dated 9/5/24 at 3:30 a.m., indicated Resident B woke up and said she was smelling chemicals in her room, and they had gotten all over her. The resident was assisted back to her room. After she received assistance with cleaning up and changing her clothes, she began coughing and yelling in the hallway. She said she needed some fresh air. The resident yelled, cussed, and spit at the staff. The resident calmed down, and the nurse was notified.

A Behavior Note, dated 9/5/24 at 5:33 p.m., indicated emergency services were called for assistance with the resident for behaviors that were unable to be redirected by staff.

The Progress Notes lacked notification of the medical provider, the DON, or the

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resident representative.

A Progress Note, dated 9/5/24 at 8:25 p.m., indicated the resident returned from the hospital via a private vehicle accompanied by her family.

During an interview, on 9/20/24 at 3:03 p.m., the DON indicated she had no additional information regarding Resident B's transfer to the hospital on 9/5/24.

During an interview, on 9/20/24 at 4:45 p.m., the Administrator indicated when a resident was transferred to the hospital, the family, the physician, and the DON should be notified.

During an interview, on 9/20/24 at 4:46 p.m., the DON indicated the notifications should be documented in the resident's clinical record.

A facility policy, last revised 4/23/24 and provided by the Administrator on 9/20/24 at 12:18 p.m., titled "Notification of Changes in Resident Status," indicated "... A. The Administrator or the Director of Nursing or designee will notify the Resident's provider when a change in a resident's mental or physical status is observed by staff. Reporting will be within 24 hours after the observation. Serious or life-threatening situation should be reported to the provider immediately after

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	activating the Emergency Management Services (911). B. The Administrator or the Director of Nursing or designee will notify the resident representative when a resident's accident/incident requires transfer out to the community" This citation relates to Complaint IN00442720.			
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 record review and interview, the facility failed to provide adequate supervision and interventions to prevent resident-to-resident abuse resulting in one resident receiving a lip laceration requiring sutures for 2 of 2 resident reviewed for resident altercations. (Resident D and Resident E)	R 0052	<u>1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</u> Resident D returned from inpatient psych hospital with new medication management, resident doing well on Memory Care. Resident E lip healed and showing no negative effects from incident. <u>2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u> All residents on Memory Care area have the potential to be affected by the alleged deficient practice.	10/20/2024

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Finding includes: During an observation, on 9/20/24 at 10:45 a.m., QMA 3 and LPN 4 were standing outside Resident E's room. At the same time, QMA 3 indicated Resident D had been transferred to a behavioral health facility, and she was waiting for Resident E to finish up getting ready for an outside appointment. The resident did not like anyone to bother her while getting ready. 1. Resident E's clinical record was reviewed on 9/20/24 at 1:13 p.m. Diagnoses included dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety. A facility incident report, dated 9/14/24 at 11:45 a.m., indicated Resident E said Resident D hit her in the mouth with a coffee cup. There were no witnesses. The resident had a split on the right side of her top lip, with active bleeding. At 12:00 p.m., the resident was taken to the hospital by the family. The resident returned from the hospital with stitches to her lip laceration and an antibiotic for seven days. A hospital Patient Visit Information paper, dated 9/14/24 at 2:14 p.m., indicated Resident E received sutures to	3 Crisis behavior Intervention and Behavior Management/ Prevention of Resident to Resident Altercation, Policy for change of condition education to nursing staff 10/09/2024 by Director of Nursing. Dementia Specific Training November 5th-6th 2024. Memory care rounds will be done daily for 30 days, 3 times a week for 30 days, then weekly for 4 months by Executive Director and/or designee to observe resident engagement and staff oversight. 4 Audits will be reviewed in monthly QA meetings for 6 months. QA committee will make recommendations for need of ongoing audits. 5 Compliance date 10/20/2024	
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the lip and a new order for amoxicillin potassium clavulanate (antibiotic).

Physician's orders included amoxicillin/potassium clavulanate 875-125 mg (milligrams) twice a day for seven days (9/14/24).

2. Resident D's clinical record was reviewed on 9/20/24 at 1:29 p.m. Diagnoses included dementia, severe, with behavioral disturbance, recurrent depressive disorder, unspecified mood (affective) disorder, anxiety disorder, adjustment disorder, and other sexual disorders.

Physician's orders included behavioral note three times a day (5/20/24) and risperidone (antipsychotic) twice a day (5/20/24).

A Nurse Practitioner Note, dated 5/21/24 at 4:05 p.m., indicated the resident was seen to follow up from a 5/10/24 to 5/20/24 stay at a behavioral health facility. He had been sent to the behavioral health facility due to a peer-to-peer altercation.

A Behavior Note, dated 6/28/24 at 2:00 p.m., indicated the resident displayed confrontational behaviors toward other residents. The staff had to intervene twice. The resident aggressively grabbed a staff member's wrists and

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touched her inappropriately.

A Behavior Note, dated 7/1/24 at 6:06 p.m., indicated the resident cussed at and threatened another resident in the dining room.

A Behavior Note, dated 7/1/24 at 7:10 p.m., indicated the resident was transferred to the hospital for evaluation and treatment. Initially, he had refused to go with the ambulance driver. With redirection, he sat on the stretcher and left the facility.

A Behavior Note, dated 7/28/24 at 8:22 p.m., indicated the resident went into other residents' rooms, upsetting them.

A Behavior Note, dated 8/8/24 at 8:16 p.m., indicated the resident went into other residents' rooms, upsetting them. He dug through trash cans looking for things to put in his walker.

A Behavior Note, dated 8/21/24 at 9:39 p.m., indicated at the beginning of the shift, the resident was making other residents upset. He picked up wet floor signs and acted like he was going to hit someone with them.

A Behavior Note, dated 9/7/24 at 10:39 a.m., indicated the writer was notified the resident

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had smacked another resident, but it was not witnessed.

Resident D's CNA/Nurses Notes, provided by the DON on 9/20/24 at 1:00 p.m., indicated on 9/14/24 at 12:00 p.m., Resident E had reported she had been struck by Resident D in the mouth with a coffee cup at 11:20 a.m. According to staff who walked in after the incident occurred, Resident D had a coffee cup in his hand. Resident E had an injury to her top lip. She pointed to Resident D and said he did it.

A CNA sheet, with descriptions of the residents' needs on the secured unit, provided by QMA 3 on 9/20/24 at 12:46 p.m., indicated Resident D required assistance with toileting every two hours. His room was to be checked every two hours to make sure he had not hidden briefs anywhere. He was to be assisted with dressing in the morning by third shift. The sheet did not list interventions for aggressive behaviors or to monitor for aggressive behaviors.

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During an interview, on 9/20/24 at 12:52 p.m., QMA 3 indicated she was surprised when she heard of the resident's aggressive behavior on 9/14/24. She had not seen or heard of aggressive behaviors exhibited by the resident.

During an interview, on 9/20/24 at 12:56 p.m., CNA 6 indicated he worked with a staffing agency and had not been at the facility before today. QMA 3 had gone over the residents needs with him. He also had the CNA sheet to help guide him.

During an interview, on 9/20/24 at 1:10 p.m., the DON indicated she had not had full access to the residents' clinical records since she started on 9/9/24. She did not know of any prior behavioral incidents from Resident D.

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During an interview, on 9/20/24 at 4:44 p.m., the Administrator indicated the altercation between Resident D and Resident E had been reviewed on the camera as there were no witnesses to the altercation. Resident E had pointed at Resident D. Resident D reached out with his left hand, pushed Resident E on her forehead, and caused her to fall. Resident D did not hit Resident E with a coffee cup. Resident E received a laceration on her lip from the fall which required sutures.

A facility policy, last revised 1/6/23, provided by the Administrator on 9/20/24 at 12:18 p.m., titled "Behavior Management," indicated "...Interventions will be implemented to prevent or minimize behavioral occurrences that could potentially cause disruption or harm to self or others"

Cross reference R349.

This citation relates to Complaint IN00443300.

Based on record review and interview, the facility failed to provide adequate supervision and interventions to prevent resident-to-resident abuse resulting in one resident receiving a lip laceration requiring sutures for 2 of 2 resident reviewed for resident

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altercations. (Resident D and Resident E)

Finding includes:

During an observation, on 9/20/24 at 10:45 a.m., QMA 3 and LPN 4 were standing outside Resident E's room. At the same time, QMA 3 indicated Resident D had been transferred to a behavioral health facility, and she was waiting for Resident E to finish up getting ready for an outside appointment. The resident did not like anyone to bother her while getting ready.

1. Resident E's clinical record was reviewed on 9/20/24 at 1:13 p.m. Diagnoses included dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance, and anxiety.

A facility incident report, dated 9/14/24 at 11:45 a.m., indicated Resident E said Resident D hit her in the mouth with a coffee cup. There were no witnesses. The resident had a split on the right side of her top lip, with active bleeding. At 12:00 p.m., the resident was taken to the hospital by the family. The resident returned from the hospital with stitches to her lip laceration and an antibiotic for seven days.

A hospital Patient Visit Information paper, dated

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9/14/24 at 2:14 p.m., indicated Resident E received sutures to the lip and a new order for amoxicillin potassium clavulanate (antibiotic).

Physician's orders included amoxicillin/potassium clavulanate 875-125 mg (milligrams) twice a day for seven days (9/14/24).

2. Resident D's clinical record was reviewed on 9/20/24 at 1:29 p.m. Diagnoses included dementia, severe, with behavioral disturbance, recurrent depressive disorder, unspecified mood (affective) disorder, anxiety disorder, adjustment disorder, and other sexual disorders.

Physician's orders included behavioral note three times a day (5/20/24) and risperidone (antipsychotic) twice a day (5/20/24).

A Nurse Practitioner Note, dated 5/21/24 at 4:05 p.m., indicated the resident was seen to follow up from a 5/10/24 to 5/20/24 stay at a behavioral health facility. He had been sent to the behavioral health facility due to a peer-to-peer altercation.

A Behavior Note, dated 6/28/24 at 2:00 p.m., indicated the resident displayed confrontational behaviors toward other residents. The staff had to intervene twice. The

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resident aggressively grabbed a staff member's wrists and touched her inappropriately.

A Behavior Note, dated 7/1/24 at 6:06 p.m., indicated the resident cussed at and threatened another resident in the dining room.

A Behavior Note, dated 7/1/24 at 7:10 p.m., indicated the resident was transferred to the hospital for evaluation and treatment. Initially, he had refused to go with the ambulance driver. With redirection, he sat on the stretcher and left the facility.

A Behavior Note, dated 7/28/24 at 8:22 p.m., indicated the resident went into other residents' rooms, upsetting them.

A Behavior Note, dated 8/8/24 at 8:16 p.m., indicated the resident went into other residents' rooms, upsetting them. He dug through trash cans looking for things to put in his walker.

A Behavior Note, dated 8/21/24 at 9:39 p.m., indicated at the beginning of the shift, the resident was making other residents upset. He picked up wet floor signs and acted like he was going to hit someone with them.

A Behavior Note, dated 9/7/24

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at 10:39 a.m., indicated the writer was notified the resident had smacked another resident, but it was not witnessed.

Resident D's CNA/Nurses Notes, provided by the DON on 9/20/24 at 1:00 p.m., indicated on 9/14/24 at 12:00 p.m., Resident E had reported she had been struck by Resident D in the mouth with a coffee cup at 11:20 a.m. According to staff who walked in after the incident occurred, Resident D had a coffee cup in his hand. Resident E had an injury to her top lip. She pointed to Resident D and said he did it.

A CNA sheet, with descriptions of the residents' needs on the secured unit, provided by QMA 3 on 9/20/24 at 12:46 p.m., indicated Resident D required assistance with toileting every two hours. His room was to be checked every two hours to make sure he had not hidden briefs anywhere. He was to be assisted with dressing in the morning by third shift. The sheet did not list interventions for aggressive behaviors or to monitor for aggressive behaviors.

During an interview, on 9/20/24 at 12:52 p.m., QMA 3 indicated she was surprised when she heard of the resident's aggressive behavior on 9/14/24. She had not seen or heard of

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aggressive behaviors exhibited by the resident.

During an interview, on 9/20/24 at 12:56 p.m., CNA 6 indicated he worked with a staffing agency and had not been at the facility before today. QMA 3 had gone over the residents needs with him. He also had the CNA sheet to help guide him.

During an interview, on 9/20/24 at 1:10 p.m., the DON indicated she had not had full access to the residents' clinical records since she started on 9/9/24. She did not know of any prior behavioral incidents from Resident D.

During an interview, on 9/20/24 at 4:44 p.m., the Administrator indicated the altercation between Resident D and Resident E had been reviewed on the camera as there were no witnesses to the altercation. Resident E had pointed at Resident D. Resident D reached out with his left hand, pushed Resident E on her forehead, and caused her to fall. Resident D did not hit Resident E with a coffee cup. Resident E received a laceration on her lip from the fall which required sutures.

A facility policy, last revised 1/6/23, provided by the Administrator on 9/20/24 at 12:18 p.m., titled "Behavior Management," indicated "

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	...Interventions will be implemented to prevent or minimize behavioral occurrences that could potentially cause disruption or harm to self or others" Cross reference R349. This citation relates to Complaint IN00443300.			
R 0297	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(c)(1) (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were administered to residents during scheduled times for 5 of 6 residents reviewed for late and missed medications (Resident G, Resident H, Resident J, Resident K, Resident L). Findings include: 1. Resident G's clinical record was reviewed on 9/20/24 at	R 0297	1 <u>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</u> Resident G, Resident H, Resident K and Resident L showed no negative outcome from alleged deficient practice.	10/20/2024

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11:10 a.m. Diagnoses included, but were not limited to, heart failure, hyperlipidemia, parkinson's disease, essential (primary) hypertension, and major depressive disorder, recurrent. Current medications included, but were not limited to, amlodipine besylate (high blood pressure) 5 milligram (mg) once daily, bupropion (major depressive disorder) 150 mg twice daily, clonazepam (major depressive disorder) 1 mg twice daily, hydrochlorothiazide (high blood pressure) 25 mg daily, lisinopril (high blood pressure) 40 mg daily, Nuplazid (Parkinson's) 34 mg daily, pantoprazole (indigestion) 40 mg daily, propranolol (hypertension) 20 mg twice daily, and potassium (heart failure) 20 mEq (milliequivalent) daily. A September 2024 Medication Administration Report (MAR) indicated on 9/13/24 she did not receive her 8:00 a.m. dose of propranolol. On 9/15/24, she did not receive her 8:00 a.m. doses of lisinopril, Miralax, Nuplazid, pantoprazole and potassium. 2. Resident H's clinical record was reviewed on 9/20/24 at 11:45 a.m. Diagnoses included, but were not limited to, major	2 <u>How</u> <u>the facility will identify other residents having the potential to be affected</u> <u>by the same deficient practice and what corrective action will be taken;</u> All residents that receive medication administration have the potential to be affected by the deficient practice. No other residents noted negative outcomes from alleged deficient practice. 3 Nursing staff educated on Medication Management 10/09/2024 by Director of Nursing. New hire of nurses and QMA's to reduce agency staff completing med pass. Medication administration records are to be audited 3 times a week for 4 weeks, weekly for 2 months, then monthly for 2 months by the Director of Nursing and/or designee. 4 Audits will be reviewed monthly in QA meetings for 6 months, committee to make recommendations for need of ongoing audits.	
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depressive disorder, diabetes mellitus with diabetic neuropathy, anxiety disorder, rheumatoid arthritis, hyperlipidemia and congestive heart failure.

Current medications included, but were not limited to, aripiprazole (antipsychotic) 2 mg daily, atorvastatin (high cholesterol) 20 mg daily, citalopram (major depressive disorder) 20 mg daily, and levothyroxine (hypothyroidism) 75 mcg (micrograms) daily.

A September 2024 Medication Administration Report indicated, on 9/19/24, she did not receive her 8:00 a.m. doses of aripiprazole, atorvastatin, citalopram, Restasis eye drops and vitamin B- 12.

3. Resident J's clinical record was reviewed on 9/20/24 at 12:45 p.m. Diagnoses included, but were not limited to, vitamin B-12 deficiency, diabetes mellitus with diabetic chronic kidney disease and polyneuropathy, dementia, major depressive disorder, primary hypertension, congestive heart failure, chronic kidney disease, stage 4.

Current medications included, but were not limited to, Humalog (diabetes) subcutaneous per sliding scale, insulin glargine (diabetes) 44 units

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FORM APPROVED

OMB NO. 0938-0391

subcutaneously daily, and losartan potassium (high blood pressure) 25 mg daily.

A September 2024 Medication Administration Report indicated he did not receive his insulin glargine 44 units subcutaneously on 9/8/24 at 7:00 p.m. He also did not receive his Humalog insulin per his sliding scale on 9/6/24 at 4:00 p.m. and 9/9/24 at 4:00 p.m.

There were no documented blood glucose checks for 9/6/24 at 4:00 p.m. and 9/9/24 at 4:00 p.m.

4. Resident K's clinical record was reviewed on 9/20/24 at 1:10 p.m. Diagnoses included, but were not limited to, hypothyroidism, primary insomnia, other idiopathic peripheral autonomic neuropathy, primary hypertension, and chronic kidney disease, stage 4.

Current medications included, but were not limited to, aspirin 81 mg daily, gabapentin (nerve pain) 300 mg (2 tablets) three times a day, hydrocodone-acetaminophen (pain) 7.5-325 mg every 6 hours, levothyroxine (hypothyroidism) 125 mcg tablet daily, and torsemide (hypertension) 20 mg daily.

A September 2024 Medication Administration Report indicated

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she did not receive her scheduled hydrocodone-acetaminophen doses on 9/9/24 at 12:00 a.m. and 6:00 p.m., 9/10/24 at 12:00 a.m. and 6:00 a.m., and 9/11/24 at 12:00 a.m. and 6:00 a.m.

5. Resident L's clinical record was on 9/20/24 at 2:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, hyperlipidemia, primary hypertension, endocarditis, chronic kidney disease, stage 4.

Current medications included, but were not limited to, hydralazine (hypertension) 25 mg three times a day, Lipitor (cholesterol) 40 mg daily, Novolog insulin (diabetes) subcutaneous per sliding scale, and Tradjenta (diabetes) 5 mg daily.

A September 2024 Medication Administration Report indicated he did not receive his Novolog insulin subcutaneously per sliding scale on 9/9/24 at 5:00 p.m. and on 9/12/24 at 5:00 p.m.

There were no documented blood glucose checks for 9/9/24 at 5:00 p.m. and 9/12/24 at 5:00 p.m.

During an interview, on 9/20/24 at 10:53 a.m., QMA 5 indicated the facility used paper MARs

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and once she administered a medication, she added a check mark along with her initials in the box for that medication time.

During an interview, on 9/20/24 at 3:07 p.m., the DON indicated that as far as she was aware, medications had been given on time. Other than the facility having a lot of agency staff members, she was not sure why the medications haven't been signed off as given.

A current policy, titled "Medication Management, Administration, and Storage (Indiana and Ohio only)," left on the table on 9/20/24 at 3:47 p.m., indicated ...2. if a resident is assessed as needing assistance with medication administration, it is the responsibility of the licensed nurse or Qualified Medication Aide (QMA) to administer the medications to the resident"

This citation relates to Complaint IN00443655.

Based on interview and record review, the facility failed to ensure medications were administered to residents during scheduled times for 5 of 6 residents reviewed for late and missed medications (Resident G, Resident H, Resident J, Resident K, Resident L).

Findings include:

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1. Resident G's clinical record was reviewed on 9/20/24 at 11:10 a.m. Diagnoses included, but were not limited to, heart failure, hyperlipidemia, parkinson's disease, essential (primary) hypertension, and major depressive disorder, recurrent.

Current medications included, but were not limited to, amlodipine besylate (high blood pressure) 5 milligram (mg) once daily, bupropion (major depressive disorder) 150 mg twice daily, clonazepam (major depressive disorder) 1 mg twice daily, hydrochlorothiazide (high blood pressure) 25 mg daily, lisinopril (high blood pressure) 40 mg daily, Nuplazid (Parkinson's) 34 mg daily, pantoprazole (indigestion) 40 mg daily, propranolol (hypertension) 20 mg twice daily, and potassium (heart failure) 20 mEq (milliequivalent) daily.

A September 2024 Medication Administration Report (MAR) indicated on 9/13/24 she did not receive her 8:00 a.m. dose of propranolol.

On 9/15/24, she did not receive her 8:00 a.m. doses of lisinopril, Miralax, Nuplazid, pantoprazole and potassium.

2. Resident H's clinical record was reviewed on 9/20/24 at

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11:45 a.m. Diagnoses included, but were not limited to, major depressive disorder, diabetes mellitus with diabetic neuropathy, anxiety disorder, rheumatoid arthritis, hyperlipidemia and congestive heart failure.

Current medications included, but were not limited to, aripiprazole (antipsychotic) 2 mg daily, atorvastatin (high cholesterol) 20 mg daily, citalopram (major depressive disorder) 20 mg daily, and levothyroxine (hypothyroidism) 75 mcg (micrograms) daily.

A September 2024 Medication Administration Report indicated, on 9/19/24, she did not receive her 8:00 a.m. doses of aripiprazole, atorvastatin, citalopram, Restasis eye drops and vitamin B- 12.

3. Resident J's clinical record was reviewed on 9/20/24 at 12:45 p.m. Diagnoses included, but were not limited to, vitamin B-12 deficiency, diabetes mellitus with diabetic chronic kidney disease and polyneuropathy, dementia, major depressive disorder, primary hypertension, congestive heart failure, chronic kidney disease, stage 4.

Current medications included, but were not limited to, Humalog (diabetes) subcutaneous per

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sliding scale, insulin glargine (diabetes) 44 units subcutaneously daily, and losartan potassium (high blood pressure) 25 mg daily.

A September 2024 Medication Administration Report indicated he did not receive his insulin glargine 44 units subcutaneously on 9/8/24 at 7:00 p.m. He also did not receive his Humalog insulin per his sliding scale on 9/6/24 at 4:00 p.m. and 9/9/24 at 4:00 p.m.

There were no documented blood glucose checks for 9/6/24 at 4:00 p.m. and 9/9/24 at 4:00 p.m.

4. Resident K's clinical record was reviewed on 9/20/24 at 1:10 p.m. Diagnoses included, but were not limited to, hypothyroidism, primary insomnia, other idiopathic peripheral autonomic neuropathy, primary hypertension, and chronic kidney disease, stage 4.

Current medications included, but were not limited to, aspirin 81 mg daily, gabapentin (nerve pain) 300 mg (2 tablets) three times a day, hydrocodone-acetaminophen (pain) 7.5-325 mg every 6 hours, levothyroxine (hypothyroidism) 125 mcg tablet daily, and torsemide (hypertension) 20 mg daily.

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A September 2024 Medication Administration Report indicated she did not receive her scheduled hydrocodone-acetaminophen doses on 9/9/24 at 12:00 a.m. and 6:00 p.m., 9/10/24 at 12:00 a.m. and 6:00 a.m., and 9/11/24 at 12:00 a.m. and 6:00 a.m.

5. Resident L's clinical record was on 9/20/24 at 2:00 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus with diabetic chronic kidney disease, hyperlipidemia, primary hypertension, endocarditis, chronic kidney disease, stage 4.

Current medications included, but were not limited to, hydralazine (hypertension) 25 mg three times a day, Lipitor (cholesterol) 40 mg daily, Novolog insulin (diabetes) subcutaneous per sliding scale, and Tradjenta (diabetes) 5 mg daily.

A September 2024 Medication Administration Report indicated he did not receive his Novolog insulin subcutaneously per sliding scale on 9/9/24 at 5:00 p.m. and on 9/12/24 at 5:00 p.m.

There were no documented blood glucose checks for 9/9/24 at 5:00 p.m. and 9/12/24 at 5:00 p.m.

During an interview, on 9/20/24

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at 10:53 a.m., QMA 5 indicated the facility used paper MARs and once she administered a medication, she added a check mark along with her initials in the box for that medication time.

During an interview, on 9/20/24 at 3:07 p.m., the DON indicated that as far as she was aware, medications had been given on time. Other than the facility having a lot of agency staff members, she was not sure why the medications haven't been signed off as given.

A current policy, titled "Medication Management, Administration, and Storage (Indiana and Ohio only)," left on the table on 9/20/24 at 3:47 p.m., indicated ...2. if a resident is assessed as needing assistance with medication administration, it is the responsibility of the licensed nurse or Qualified Medication Aide (QMA) to administer the medications to the resident"

This citation relates to Complaint IN00443655.

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. Based on interview and record review, the facility failed to maintain and provide staff access to accurate and up to date clinical records for the care of facility residents. This deficient practice had the potential to affect 68 residents residing in the facility. Findings include: During an interview, on 9/20/24 at 9:45 a.m., the Administrator indicated the facility was unable to access electronic medical records from the time when the former management company ran the facility. The former management company denied giving Gardant access to the resident's medical records. All current clinical records were on paper, including the medication administration records. Gardant	R 0349	<u>1 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</u> No residents effected related to alleged deficient practice. <u>2 How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</u> All residents have the potential to be affected by the deficient practice. 3 Clinical records/charts established for all residents containing information from prior electronic medical records directed by the Director of Nursing. Gardant continues to work with prior electronic medical records provider to retrieve/gain access for current and closed records. 4 QA committee will review progress on Gardant efforts on obtaining additional past medical records for 6 months.	10/20/2024
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management company took over the facility two weeks prior.

During an interview, on 9/20/24 at 10:53 a.m., QMA 5 indicated she didn't know where anything was located and was unsure if the facility had paper charts for the residents. The facility did not have a computer system in place, and the medication administration report was on paper, which included the residents' orders and diagnoses.

During an interview, on 9/20/24 at 12:10 p.m., the Administrator indicated that former management company was still refusing to give them access to the resident's electronic medical records.

During an interview, on 9/20/24 at 12:46 p.m., QMA 3 indicated they didn't have any resident charts. The facility had face sheets and medication lists that included the residents' orders and diagnoses.

During an interview, on 9/20/24 at 12:51 p.m., the DON indicated they had just gained read-only access to the residents' electronic medical records that day.

During an interview, on 9/20/24 at 1:10 p.m., the DON indicated the facility's current pharmacy assisted the facility in giving them access to Medication

5 Compliance date 10/20/24.

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Administration Records, prior physician orders, and face sheets. The facility had accessed some paper charting, but did not have full access to resident clinical records since changing management companies on 9/9/24.

Based on interview and record review, the facility failed to maintain and provide staff access to accurate and up to date clinical records for the care of facility residents. This deficient practice had the potential to affect 68 residents residing in the facility.

Findings include:

During an interview, on 9/20/24 at 9:45 a.m., the Administrator indicated the facility was unable to access electronic medical records from the time when the former management company ran the facility. The former management company denied giving Gardant access to the resident's medical records. All current clinical records were on paper, including the medication administration records. Gardant management company took over the facility two weeks prior.

During an interview, on 9/20/24 at 10:53 a.m., QMA 5 indicated she didn't know where anything was located and was unsure if the facility had paper charts for the residents. The facility did not

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have a computer system in place, and the medication administration report was on paper, which included the residents' orders and diagnoses.

During an interview, on 9/20/24 at 12:10 p.m., the Administrator indicated that former management company was still refusing to give them access to the resident's electronic medical records.

During an interview, on 9/20/24 at 12:46 p.m., QMA 3 indicated they didn't have any resident charts. The facility had face sheets and medication lists that included the residents' orders and diagnoses.

During an interview, on 9/20/24 at 12:51 p.m., the DON indicated they had just gained read-only access to the residents' electronic medical records that day.

During an interview, on 9/20/24 at 1:10 p.m., the DON indicated the facility's current pharmacy assisted the facility in giving them access to Medication Administration Records, prior physician orders, and face sheets. The facility had accessed some paper charting, but did not have full access to resident clinical records since changing management companies on 9/9/24.

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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	