STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	09/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNITY	5202 ST JOE ROAD, FORT WAYNE, , 46835

(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 IN00389614 and Complaint IN00390930. Complaint IN00389614 - Substantiated. No state residential findings related to the allegations were cited. Complaint IN00390930 - Substantiated. State Residential Findings related to the allegations are cited at R0297. Survey date: September 29 and 30, 2022 Facility number: 015503 Residential Census: 48 This State Residential Finding is cited in accordance with 410 IAC 16.2-5 Quality review completed October 4, 2022	R 0000		

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 3 of 3 residents' medications were administered per physician's order without medication error. (Resident E, Resident F, and Resident G) Findings include: 1. A review of Resident E's records began on 9/29/2022 at 2:00 PM. Diagnoses included but were not limited to, transient cerebral ischemic attack, bipolar disorder, recurrent major depressive disorder, anxiety disorder, diabetes, hypertension. A review of Resident E's orders dated September 2022, indicated to give the medication Abilify (an antipsychotic medication) 10 mg (milligram, a dose measurement) tablet 10 mg by mouth (po) in the morning related to bipolar	R 0297	**The following Plan of Correction is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne as mandated by the Indiana State Department of Health. However, this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, Fort Wayne maintains that the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by applicable regulations. We respectfully request a paper compliance for the following citation.** **R297** (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. This RULE is not met as evidenced by: R 297 Based on interview and record review, the facility failed to	10/14/2022

disorder, had an order start date of 4/23/2022.

A review of Resident E's Medication Administration Record dated September 2022 indicated Abilify 10 mg tablet was administered orally on 9/21/2022 as indicated by a check mark and QMA 1's initials.

A review of Resident E's Progress Notes indicated, On 9/21/2022 at 4:47 PM, the Director of Nursing (DON) wrote she had found an empty medication packets for Resident E with a pill in it for the 8:00 AM dose. The DON informed the facility's Nurse Practitioner (NP) and was informed to not give the missed dose at the time of day and was to wait until tomorrow morning to give the next dose.

In an interview on 9/30/2022 at 1:00 P.M., the DON indicated the Abilify 10 mg pill was not given to Resident E on 9/21/2022. She indicated she goes through all residents medication packets daily and had found the pill in the sack used to discard the given medication packets. The medication packets were observed to have an individually packaged pill identified with the resident's name, date and time the medication was to be given, name of the medication, dose

ensure 3
of 3 residents' medications were administered per physician's order without
medication error. (Resident E, Resident F, and Resident G)
Preventive measures taken by the facility, QMA 4 was terminated, training to be completed with all QMAs and
Nurses. All would be re-trained on passing medications including the "Rights of Medication" pass and paying attention. The DON, ADON and Executive Director would be doing
medication pass observations with QMAs and Nurses weekly for 6 weeks, then
bi-weekly for 8 weeks and then monthly for 6 months to ensure medications were
passes correctly.

What Corrective action(s) will be accomplished
for those residents found to have been affected by the deficient
practice? Training, monitoring and observing Medication pass process with QMA's and Nurses,
outlined below, to ensure that this process is being followed at all times. This will decrease the chances for medication
errors with Residents.

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?

The DON, ADON & ED have

	and description of the medication. The DON indicated she wrote a progress note regarding the missed medication, she indicated the MAR could not be changed in electronic record to reflect the missed medication. The DON further indicated a State Report was sent to ISDH for the incident. On 9/29/22 the facility AIT (Administrator-In-Training) provided State Reported Incidents since August 1, 2022. Review of the facility's State Reported Incident Number: 17, reported on 9/22/2022 and the incident involved Resident E and CNA 1. The DON had found Resident E's pill of Abilify stuck in the package for the 8:00 AM for 9/21/2022. The report indicated the medication was not given. The NP was notified, and was not to give the medication and was to wait until tomorrow's dose and to monitor for adverse reactions to the missed dose. The investigation to Incident Number 17, dated 9/22/2022 indicated no injury noted to resident. Incident reported to ISDH (Indiana State Department of Health) and DON to complete training with all staff. 2. A review of Resident F's records began on 9/29/2022 at 2:30 PM. Diagnoses include but not limited to hypertension, atrial		established a monitoring system to ensure that there are minimal to no medication errors for Residents. Monitoring that QMA's & Nurses are Passing medications correctly. This entails training, monitoring, & observing of Medication passing process with the QMA's and Nurses during the actual passes. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The DON, ADON & ED have established a monitoring system to ensure that this form is being used consistently & correctly. This entails training/monitoring/observing of Medication passing process. DON, ADON &/or ED will follow the Med Pass Observations with QMA's & Nurses to ensure ongoing compliance & decreasing chance of medication errors. The monitoring is: Weekly for 6 weeks, bi-weekly for 8 weeks and then monthly for 6 months to ensure medications were passed correctly. **How the corrective action(s) will be monitored to ensure the deficient practice**	

	fibrillation (A-fib), and asthma. A review of Resident F's physician order after a physician's visit on 8/19/2022 indicated furosemide (Lasix, a diuretic/water pill) 20 mg tablet was to be taken by mouth 2 times a daily for 5 days. The order was crossed out and handwritten as completed. A review of Resident F's order recapitulation dated, August 2022 listed Lasix 20 mg with an order date of 8/3/2022 and a start date of 8/4/2022. The instructions were to give Lasix 20 mg by mouth one time a day for edema. A written order was lacking on the August 2022 MAR for Lasix (furosemide) 20 mg 1 tablet 2 times a day for 5 days. The order did not indicate to administer the Lasix 2 times a day. A review of Resident F's August 2022 MAR, indicated Lasix 20 mg was administered by mouth one time daily for edema and had a discontinued date of 8/18/2022. The Lasix 20 mg was administered 1 time a day at 8:00 AM beginning on 8/4/2022 through 9/18/2022. A review of Resident F's order recapitulation dated September 2022 listed an order for Apixaban (Eliquis, to prevent blood clots, used to treat atrial fibrillation) 5 mg tablet with a		**will not recur, i.e., what quality assurance program will be put into place?** The DON, ADON and/or ED will be doing medication pass observations with QMAs and Nurses weekly for 6 weeks, bi-weekly for 8 weeks and then monthly for 6 months to ensure medications were passed correctly. Employees that have caused errors have been disciplined with Corrective Actions and 1 employee has been terminated. We take this very seriously. We are also changing Pharmacy's in order to help our team with a better pharmacy services.	

start date of 3/16/2022. Instructions to give 1 tablet 2 times a day for A-fib. The September 2022 orders also listed Metoprolol Tartrate (to treat high blood pressure) 25 mg with a start date of 3/16/2022.

A review of Resident F's nurses progress note, dated 8/18/2022 indicated Resident F had gone out for a physician's appointment. A medication orders sent with Resident F, stated they were taking Lasix 20 mg 2 times a day. The original order for Lasix was from the hospital to be taken for 5 days. The Lasix order was not updated for 5 days. Physician's office was notified. Physician's Nurse indicated the physician was out of the office and would be informed the next day for further orders regarding the Lasix order. The Physician's Nurse indicated she would call back if the physician wanted the Lasix to be continued.

A review of Resident F's September 2022 MAR indicated on 9/21/2022 on the 1700 (5:00 PM) dose listed code 09 (indicated to see Nurses Notes) with QMA 2's initials for the Apixaban 5 mg and the Metoprolol Tartrate 25 mg

A review of Resident F's nurses progress notes dated 9/21/2022 at 17:35 (5:30 PM) indicated,

	QMA 2 went to the DON and informed her the resident did not have the 5:00 PM medication packets in the medication cart. The DON checked the white bag used for disposal of the medication packets. The DON contacted the QMA 1 who had worked the prior shift. QMA 1 told the DON she did not remember but she must have given the 5:00 PM medications. The NP was contacted and ordered to monitor resident's vital signs hourly and notify NP of any changes. Resident F's B/P (blood pressure) was low at 96/54, pulse was 84 and they indicated they felt fine. The POA (Power of Attorney) was called.			

In an interview on 9/30/2022 at 1:00 PM, the DON indicated the order was not transcribed to stop medication after 5 days and should have been discontinued on after the 8/8/2022 AM dose. The DON also indicated she had the nurses and QMA's discard the medication packages into a white bag on the medication cart, which she reviews daily for monitoring of the medications given. She indicated Resident F's was given 2 doses of Eliquis and Metoprolol on 9/21/2022 AM dose. She indicated they resident was monitored hourly and was without adverse reactions. The DON indicated they report all medication errors to ISDH.

A review of State Reported incidents provided by AIT on 9/29/2022 at 11:23 AM, indicated Resident F had 2 incidents reported for medication errors, Incident Number 14 and Incident Number 16 indicated the following: Incident Number 14 was reported on 8/19/2022 by the AIT and incident occurred on 8/18/2022 at 2:01 PM, and involved Resident F and LPN 3. The incident description indicated Resident F had an order for Lasix 20 mg 2 times a day with an order date of 8/8/2022 and was to be taken for 5 days. The medication was to be stopped on 8/13/2022.

The order was not entered with a "stop date" The physician's nurse was notified the medication had continued after the 5 days. The physician was out of the office and would be notified the next day and the nurse would call back if the physician wanted the Lasix continued. The Physician office was notified again on 8/19/22, for orders for the Lasix. The incident report indicated the Nurse was trained on entering orders and stop dates into electronic orders. The facility's investigation, dated 8/18/22 indicated Resident F's order for Lasix 20 mg 2 times a day was written on 8/8/22 to be taken for 5 day, a stop date was not entered. The medication error was found on 8/18/2022. Physician's office was notified. No order given to continue Lasix.

Incident Number 16 was reported on 8/22/2022 by the AIT and the incident occurred on 9/21/2022 at 5:01 PM, and involved Resident F and QMA 1. the incident description indicated QMA 3 informed the DON, Resident F's 5:00 PM medications were not in the medication cart. The DON investigated and called QMA 1, who believed she may have given them in error with the morning medications. The investigation found Resident F was given Eliquis 2 doses at

8:00 AM and 2 doses of Metoprolol at 8:00 AM. The NP was notified and ordered to monitor B/P hourly and notify NP of any changes. POA was notified via voicemail. Immediate action taken was to notify NP and monitor blood pressure every hour for 4 hours and to notify NP if any concerns. The incident report indicated there were no concerns noted. Preventive measures indicated all QMAs were trained on the importance of paying attention and following the MAR for administration of medications. The DON's investigation was completed, resident appeared to have been given 2 doses of Eliquis and Metoprolol at 8:00 AM. No injury to resident noted. Corrective action to complete training with all staff.

3. A review of Resident G's records began on 9/29/2022 at 3:00 PM. Diagnoses included chronic pain, intervertebral disc disease of lumbar region. diabetes, anxiety disorder, hypertension and atrial fibrillation.

A review of Resident G's orders dated September 2022 listed orders for Oxycodone (opioid pain medication) 15 mg 1 tablet by mouth 1 time a day for pain, with an order date of 7/16/2022. A second order for Oxycodone 15 mg 1 tablet 3 times a day for pain, every 6 hours at 8:00 AM,

2:00 PM, 8:00 PM, and 2:00 AM, and had an order date of 7/16/2022. Another order for Oxycodone ER (Extended Release) 30 mg tablet by mouth every 12 hours for pain with an order date of 7/15/2022. A hand written order given by the facility NP, dated 9/22/2022 to send to ER (Emergency Room) for evaluation and treatment.

A review of Resident G's September 2022 MAR, indicated the OxyContin ER 20 mg was administered at 8:00 AM and at 8:00 PM Resident G was in hospital and the Oxycodone ER 20 mg was not administered. Oxycodone 20 mg was administered on 9/22/2022 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. On 6/23/2022 the 12:00 AM entry was coded 06 which indicated Resident G was in the hospital and the Oxycodone 20 mg was not administered. It was noted the OxyContin ER dose ordered was 30 mg and the MAR indicated OxyContin ER 20 mg was administered every 12 hours. It was also noted the Oxycodone 15 mg dose was ordered and the MAR indicated Oxycodone 20 mg was administered every 6 hours,

A review of Resident G's nursing progress note dated 9/22/2022 at 6:09 PM, QMA 4 notified the DON, Resident G had been given the wrong

medication (Oxycodone) at 12:00 PM and 6:00 PM. Resident F takes OxyContin (Oxycodone) 20 mg ER every 12 hours at 8:00 AM and 8:00 PM. Oxycodone 20 mg every 6 hours as needed. Instead of giving the prn Oxycodone 20 mg, the Resident's OxyContin 20 mg ER was given. The DON and ADON (Assistant Director of Nursing) assessed Resident G, vital signs taken, blood pressure was 129/77, pulse 118, respirations were 16 and oxygen saturation level was 77 (under 90 is considered low, lower than 60 requires oxygen supplement). Resident f's head of bed was elevated and Resident's oxygen was put on. An order was received from the facility's NP to send to ER for evaluation and treatment. Resident G was transported to the hospital via EMS (Emergency Medical Service). Resident G's family member was notified, message left to return call to facility.

A review of Resident G's hospital summary dated 9/22/2022 indicated diagnosis of medication overdose. Facility wrote on the header of the Hospital Summary, came back at 3:00 AM.

An interview with the DON on 9/30/22 at 12:45 PM, during review of Resident G's orders indicated Resident had 2 orders

for the Oxycodone 15 mg due to the electronic record system would not allow to enter 4 administration times, only 3 and had to add a second entry so the medication could be administered every 6 hours at 8:00 AM, 2:00 PM, 8:00 PM and 2:00 AM. she indicated on the MAR medication administration times were listed at 0000, 0600, 1200, 1800 (12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM) She indicated the OxyContin ER 20 mg tablet was to be given every 12 hours at 8:00 AM and 8:00 PM, and listed as 0800 and 2000 hours on the MAR. She indicated QMA 4 had reported the medication error. She indicated the MAR could not be corrected to reflect the medication error and a nurses note was written to indicate the medication error that occurred. She further indicated QMA 4 was terminated.

A review of the State Reported Incident Number 18 was provided by the AIT on 9/29/2022 at 11:23 AM, indicated the AIT reported Incident 18 on 9/23/2022 and involved Resident G and QMA 4. The incident occurred on 9/22/2022 at 6:01 PM. The incident description indicated the DON was informed by QMA 4 that Resident G was given the wrong medication at 12:00 PM and 6:00 PM. Resident G was given OxyContin 20 mg ER at

12:00 PM and 6:00 PM instead of the PRN (as needed)Oxycodone 20 mg ordered every 6 hours. The DON assessed the resident. Type of Injury indicated Resident G was sent to ER for evaluation. Resident G was sent back to facility approximately 8 hours later and appears to be no injury. Immediate action taken was the DON assessed resident, took vital signs, raised the head of the bed and put oxygen on Resident G. The NP was notified and an order to send to ER for evaluation and treatment. Resident was sent to the Hospital ER by EMS and family member was notified. Preventive measures taken by the facility, QMA 4 was terminated, training to be completed with all QMAs and Nurses. All would be re-trained on passing medications including the "Rights of Medication" pass and paying attention. The DON, ADON and Executive Director would be doing medication pass observations with QMAs and Nurses weekly for 6 weeks, then bi-weekly for 8 weeks and then monthly for 6 months to ensure medications were passes correctly. The DON completed an investigation of the reported medication error.

A review of a current facility policy dated 10/1/2021, titled, Medication & Treatment

Administration Assistance, was provided by the ADON on 9/30/2022 at 11:50 AM, indicated, "...Medication Administration/Assistance and /or Treatment shall be provided in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider...3. Medications assistance and administration should be in accordance with the prescriber's orders...5. The individual assisting and/or administering the medication should check the label 3 times to verify the right medication, right dose, right time and right method of administration before giving the medication...13. When assisting with a controlled substance: a. Obtain the Controlled Substances binder. b. Turn to the Controlled Substance Count Sheet that corresponds to the label on the medication container verify: i. Resident's name. ii. Drug name. iii. Health care provider's name. iv. Drug prescription number. c. Count the number of tablets/capsules or measurement of liquid available before preparing the tablet/capsule for distribution. d. Compare the actual number available with the number of the next blank row on the count sheet. Both numbers should be the same. i. If the two amounts are not the same, notify the nurse. Director of Health and Wellness, Executive Director or

designee immediately. they will provide directions immediately. e. Sign you name and note the date and time on the next blank line on the form. Do not leave a blank line on the form...."

A review of a current facility policy, dated 10/2/2022, titled, Medication Administration Record, was provided by the ADON on 9/30/2022 at 11:50 AM, indicated, "...Each resident must have a Medication Administration Record that becomes a permanent part of the resident's record, A record of the resident's medication may be paper-based or in an electronic system...2. the community associate shall document on a MAR or eMAR all medications administered to the resident...The MAR should include: a. Name of the resident. b. Date prescribed. c. Drug product name. d. Dosage. e. Strength of the drug. f. Route. g. How often the medications is to be taken. h. Diagnosis, condition, or specific indications for administrating the drug or supplement...j. Date the medication is discontinued or changed...k. Any medication errors or omissions...."

This state citation is related to Complaint IN00390930.

Based on interview and record review, the facility failed to ensure 3 of 3 residents'

medications were administered per physician's order without medication error. (Resident E, Resident F, and Resident G)

Findings include:

1. A review of Resident E's records began on 9/29/2022 at 2:00 PM. Diagnoses included but were not limited to, transient cerebral ischemic attack, bipolar disorder, recurrent major depressive disorder, anxiety disorder, diabetes, hypertension.

A review of Resident E's orders dated September 2022, indicated to give the medication Abilify (an antipsychotic medication) 10 mg (milligram, a dose measurement) tablet 10 mg by mouth (po) in the morning related to bipolar disorder, had an order start date of 4/23/2022.

A review of Resident E's Medication Administration Record dated September 2022 indicated Abilify 10 mg tablet was administered orally on 9/21/2022 as indicated by a check mark and QMA 1's initials.

A review of Resident E's Progress Notes indicated, On 9/21/2022 at 4:47 PM, the Director of Nursing (DON) wrote she had found an empty medication packets for Resident E with a pill in it for the 8:00 AM

dose. The DON informed the facility's Nurse Practitioner (NP) and was informed to not give the missed dose at the time of day and was to wait until tomorrow morning to give the next dose.

In an interview on 9/30/2022 at 1:00 P.M., the DON indicated the Abilify 10 mg pill was not given to Resident E on 9/21/2022. She indicated she goes through all residents medication packets daily and had found the pill in the sack used to discard the given medication packets. The medication packets were observed to have an individually packaged pill identified with the resident's name, date and time the medication was to be given, name of the medication, dose and description of the medication. The DON indicated she wrote a progress note regarding the missed medication, she indicated the MAR could not be changed in electronic record to reflect the missed medication. The DON further indicated a State Report was sent to ISDH for the incident.

On 9/29/22 the facility AIT (Administrator-In-Training) provided State Reported Incidents since August 1, 2022. Review of the facility's State Reported Incident Number: 17, reported on 9/22/2022 and the

incident involved Resident E and CNA 1. The DON had found Resident E's pill of Abilify stuck in the package for the 8:00 AM for 9/21/2022. The report indicated the medication was not given. The NP was notified, and was not to give the medication and was to wait until tomorrow's dose and to monitor for adverse reactions to the missed dose. The investigation to Incident Number 17, dated 9/22/2022 indicated no injury noted to resident. Incident reported to ISDH (Indiana State Department of Health) and DON to complete training with all staff.

2. A review of Resident F's records began on 9/29/2022 at 2:30 PM. Diagnoses include but not limited to hypertension, atrial fibrillation (A-fib), and asthma.

A review of Resident F's physician order after a physician's visit on 8/19/2022 indicated furosemide (Lasix, a diuretic/water pill) 20 mg tablet was to be taken by mouth 2 times a daily for 5 days. The order was crossed out and handwritten as completed.

A review of Resident F's order recapitulation dated, August 2022 listed Lasix 20 mg with an order date of 8/3/2022 and a start date of 8/4/2022. The instructions were to give Lasix 20 mg by mouth one time a day

for edema. A written order was lacking on the August 2022 MAR for Lasix (furosemide) 20 mg 1 tablet 2 times a day for 5 days. The order did not indicate to administer the Lasix 2 times a day.

A review of Resident F's August 2022 MAR, indicated Lasix 20 mg was administered by mouth one time daily for edema and had a discontinued date of 8/18/2022. The Lasix 20 mg was administered 1 time a day at 8:00 AM beginning on 8/4/2022 through 9/18/2022.

A review of Resident F's order recapitulation dated September 2022 listed an order for Apixaban (Eliquis, to prevent blood clots, used to treat atrial fibrillation) 5 mg tablet with a start date of 3/16/2022. Instructions to give 1 tablet 2 times a day for A-fib. The September 2022 orders also listed Metoprolol Tartrate (to treat high blood pressure) 25 mg with a start date of 3/16/2022.

A review of Resident F's nurses progress note, dated 8/18/2022 indicated Resident F had gone out for a physician's appointment. A medication orders sent with Resident F, stated they were taking Lasix 20 mg 2 times a day. The original order for Lasix was from the hospital to be taken for 5 days.

The Lasix order was not updated for 5 days. Physician's office was notified. Physician's Nurse indicated the physician was out of the office and would be informed the next day for further orders regarding the Lasix order. The Physician's Nurse indicated she would call back if the physician wanted the Lasix to be continued.

A review of Resident F's September 2022 MAR indicated on 9/21/2022 on the 1700 (5:00 PM) dose listed code 09 (indicated to see Nurses Notes) with QMA 2's initials for the Apixaban 5 mg and the Metoprolol Tartrate 25 mg

A review of Resident F's nurses progress notes dated 9/21/2022 at 17:35 (5:30 PM) indicated, QMA 2 went to the DON and informed her the resident did not have the 5:00 PM medication packets in the medication cart. The DON checked the white bag used for disposal of the medication packets. The DON contacted the QMA 1 who had worked the prior shift. QMA 1 told the DON she did not remember but she must have given the 5:00 PM medications. The NP was contacted and ordered to monitor resident's vital signs hourly and notify NP of any changes. Resident F's B/P (blood pressure) was low at 96/54, pulse was 84 and they indicated they felt fine. The POA

(Power of Attorney) was called.

In an interview on 9/30/2022 at 1:00 PM, the DON indicated the order was not transcribed to stop medication after 5 days and should have been discontinued on after the 8/8/2022 AM dose. The DON also indicated she had the nurses and QMA's discard the medication packages into a white bag on the medication cart, which she reviews daily for monitoring of the medications given. She indicated Resident F's was given 2 doses of Eliquis and Metoprolol on 9/21/2022 AM dose. She indicated they resident was monitored hourly and was without adverse reactions. The DON indicated they report all medication errors to ISDH.

A review of State Reported incidents provided by AIT on 9/29/2022 at 11:23 AM, indicated Resident F had 2 incidents reported for medication errors, Incident Number 14 and Incident Number 16 indicated the following: Incident Number 14 was reported on 8/19/2022 by the AIT and incident occurred on 8/18/2022 at 2:01 PM, and involved Resident F and LPN 3. The incident description indicated Resident F had an order for Lasix 20 mg 2 times a day with an order date of 8/8/2022 and was to be taken

for 5 days. The medication was to be stopped on 8/13/2022. The order was not entered with a "stop date" The physician's nurse was notified the medication had continued after the 5 days. The physician was out of the office and would be notified the next day and the nurse would call back if the physician wanted the Lasix continued. The Physician office was notified again on 8/19/22, for orders for the Lasix. The incident report indicated the Nurse was trained on entering orders and stop dates into electronic orders. The facility's investigation, dated 8/18/22 indicated Resident F's order for Lasix 20 mg 2 times a day was written on 8/8/22 to be taken for 5 day, a stop date was not entered. The medication error was found on 8/18/2022. Physician's office was notified. No order given to continue Lasix.

Incident Number 16 was reported on 8/22/2022 by the AIT and the incident occurred on 9/21/2022 at 5:01 PM, and involved Resident F and QMA 1. the incident description indicated QMA 3 informed the DON, Resident F's 5:00 PM medications were not in the medication cart. The DON investigated and called QMA 1, who believed she may have given them in error with the morning medications. The

investigation found Resident F was given Eliquis 2 doses at 8:00 AM and 2 doses of Metoprolol at 8:00 AM. The NP was notified and ordered to monitor B/P hourly and notify NP of any changes. POA was notified via voicemail. Immediate action taken was to notify NP and monitor blood pressure every hour for 4 hours and to notify NP if any concerns. The incident report indicated there were no concerns noted. Preventive measures indicated all QMAs were trained on the importance of paying attention and following the MAR for administration of medications. The DON's investigation was completed, resident appeared to have been given 2 doses of Eliquis and Metoprolol at 8:00 AM. No injury to resident noted. Corrective action to complete training with all staff.

3. A review of Resident G's records began on 9/29/2022 at 3:00 PM. Diagnoses included chronic pain, intervertebral disc disease of lumbar region. diabetes, anxiety disorder, hypertension and atrial fibrillation.

A review of Resident G's orders dated September 2022 listed orders for Oxycodone (opioid pain medication) 15 mg 1 tablet by mouth 1 time a day for pain, with an order date of 7/16/2022. A second order for Oxycodone

15 mg 1 tablet 3 times a day for pain, every 6 hours at 8:00 AM, 2:00 PM, 8:00 PM, and 2:00 AM, and had an order date of 7/16/2022. Another order for Oxycodone ER (Extended Release) 30 mg tablet by mouth every 12 hours for pain with an order date of 7/15/2022. A hand written order given by the facility NP, dated 9/22/2022 to send to ER (Emergency Room) for evaluation and treatment.

A review of Resident G's September 2022 MAR, indicated the OxyContin ER 20 mg was administered at 8:00 AM and at 8:00 PM Resident G was in hospital and the Oxycodone ER 20 mg was not administered. Oxycodone 20 mg was administered on 9/22/2022 at 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM. On 6/23/2022 the 12:00 AM entry was coded 06 which indicated Resident G was in the hospital and the Oxycodone 20 mg was not administered. It was noted the OxyContin ER dose ordered was 30 mg and the MAR indicated OxyContin ER 20 mg was administered every 12 hours. It was also noted the Oxycodone 15 mg dose was ordered and the MAR indicated Oxycodone 20 mg was administered every 6 hours,

A review of Resident G's nursing progress note dated 9/22/2022 at 6:09 PM, QMA 4

notified the DON, Resident G had been given the wrong medication (Oxycodone) at 12:00 PM and 6:00 PM. Resident F takes OxyContin (Oxycodone) 20 mg ER every 12 hours at 8:00 AM and 8:00 PM. Oxycodone 20 mg every 6 hours as needed. Instead of giving the prn Oxycodone 20 mg, the Resident's OxyContin 20 mg ER was given. The DON and ADON (Assistant Director of Nursing) assessed Resident G, vital signs taken, blood pressure was 129/77, pulse 118, respirations were 16 and oxygen saturation level was 77 (under 90 is considered low, lower than 60 requires oxygen supplement). Resident f's head of bed was elevated and Resident's oxygen was put on. An order was received from the facility's NP to send to ER for evaluation and treatment. Resident G was transported to the hospital via EMS (Emergency Medical Service). Resident G's family member was notified, message left to return call to facility.

A review of Resident G's hospital summary dated 9/22/2022 indicated diagnosis of medication overdose. Facility wrote on the header of the Hospital Summary, came back at 3:00 AM.

An interview with the DON on 9/30/22 at 12:45 PM, during

review of Resident G's orders indicated Resident had 2 orders for the Oxycodone 15 mg due to the electronic record system would not allow to enter 4 administration times, only 3 and had to add a second entry so the medication could be administered every 6 hours at 8:00 AM, 2:00 PM, 8:00 PM and 2:00 AM. she indicated on the MAR medication administration times were listed at 0000, 0600, 1200, 1800 (12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM) She indicated the OxyContin ER 20 mg tablet was to be given every 12 hours at 8:00 AM and 8:00 PM, and listed as 0800 and 2000 hours on the MAR. She indicated QMA 4 had reported the medication error. She indicated the MAR could not be corrected to reflect the medication error and a nurses note was written to indicate the medication error that occurred. She further indicated QMA 4 was terminated.

A review of the State Reported Incident Number 18 was provided by the AIT on 9/29/2022 at 11:23 AM, indicated the AIT reported Incident 18 on 9/23/2022 and involved Resident G and QMA 4. The incident occurred on 9/22/2022 at 6:01 PM. The incident description indicated the DON was informed by QMA 4 that Resident G was given the wrong medication at 12:00 PM

and 6:00 PM. Resident G was given OxyContin 20 mg ER at 12:00 PM and 6:00 PM instead of the PRN (as needed)Oxycodone 20 mg ordered every 6 hours. The DON assessed the resident. Type of Injury indicated Resident G was sent to ER for evaluation. Resident G was sent back to facility approximately 8 hours later and appears to be no injury. Immediate action taken was the DON assessed resident, took vital signs, raised the head of the bed and put oxygen on Resident G. The NP was notified and an order to send to ER for evaluation and treatment. Resident was sent to the Hospital ER by EMS and family member was notified. Preventive measures taken by the facility, QMA 4 was terminated, training to be completed with all QMAs and Nurses. All would be re-trained on passing medications including the "Rights of Medication" pass and paying attention. The DON, ADON and Executive Director would be doing medication pass observations with QMAs and Nurses weekly for 6 weeks, then bi-weekly for 8 weeks and then monthly for 6 months to ensure medications were passes correctly. The DON completed an investigation of the reported medication error.

A review of a current facility

policy dated 10/1/2021, titled, Medication & Treatment Administration Assistance, was provided by the ADON on 9/30/2022 at 11:50 AM, indicated, "...Medication Administration/Assistance and /or Treatment shall be provided in a safe and timely manner, and as prescribed by the resident's physician/healthcare provider...3. Medications assistance and administration should be in accordance with the prescriber's orders...5. The individual assisting and/or administering the medication should check the label 3 times to verify the right medication, right dose, right time and right method of administration before giving the medication...13. When assisting with a controlled substance: a. Obtain the Controlled Substances binder. b. Turn to the Controlled Substance Count Sheet that corresponds to the label on the medication container verify: i. Resident's name. ii. Drug name. iii. Health care provider's name. iv. Drug prescription number. c. Count the number of tablets/capsules or measurement of liquid available before preparing the tablet/capsule for distribution. d. Compare the actual number available with the number of the next blank row on the count sheet. Both numbers should be the same. i. If the two amounts are not the same, notify the

nurse. Director of Health and Wellness, Executive Director or designee immediately. they will provide directions immediately. e. Sign you name and note the date and time on the next blank line on the form. Do not leave a blank line on the form...."

A review of a current facility policy, dated 10/2/2022, titled, Medication Administration Record, was provided by the ADON on 9/30/2022 at 11:50 AM, indicated, "...Each resident must have a Medication Administration Record that becomes a permanent part of the resident's record, A record of the resident's medication may be paper-based or in an electronic system...2. the community associate shall document on a MAR or eMAR all medications administered to the resident...The MAR should include: a. Name of the resident. b. Date prescribed. c. Drug product name. d. Dosage. e. Strength of the drug. f. Route. g. How often the medications is to be taken. h. Diagnosis, condition, or specific indications for administrating the drug or supplement...j. Date the medication is discontinued or changed...k. Any medication errors or omissions...."

This state citation is related to Complaint IN00390930.

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