

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 06/27/2025	
NAME OF PROVIDER OR SUPPLIER HERITAGE ASSISTED LIVING OF UNION CITY		STREET ADDRESS, CITY, STATE, ZIP CODE 204 STAUDT DRIVE, UNION CITY, , 47390					
(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 IN00461905, IN00461276, IN00461072, and IN00460648. Complaint IN00461276 - No deficiencies related to the allegations are cited. Complaint IN00461072 - No deficiencies related to the allegations are cited. Complaint IN00460648 - No deficiencies related to the allegations are cited. Complaint IN00461905 - State deficiencies related to the allegations are cited at R0243. Survey date: June 26 and 27, 2025 Facility number: 015887 Residential Census: 29	R 0000					

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

	These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 1, 2025.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview, the facility failed to ensure medication administration was documented per facility policy and accepted professional standards to prevent a resident receiving duplicate doses of a controlled pain medication for 1 of 5 residents reviewed for medication administration. (Resident F) Findings include: Resident F's clinical record was	R 0243	Review P&P's for medication delivery and narcotics count with all professional clinical staff. Education of resident medication administration for all professional clinical staff to be completed by 7/15/2025. Review and observe medication pass and narcotic med. count by DON for the next 45 days. Immediate action of posting to follow P&P for the 5 rights for medication delivery. All meds. to be reviewed for resident prior to administration.	07/15/2025

reviewed on 6/27/25 at 11:08 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety disorder, essential hypertension, hyperlipidemia, major depressive disorder, and rheumatoid arthritis.

Current physician orders, dated 6/13/25, included trazodone 100 milligrams (mg) take one tablet by mouth at bedtime and morphine sulfate extended release (ER) 30 mg take one tablet by mouth twice daily at 6:00 a.m. and 6:00 p.m.

During an interview with Resident F on 6/27/25 at 12:05 p.m., she indicated nursing had made some mistakes with the administration of her morphine. She was her own advocate, was familiar with all her medications, and knew when those medications were to be given. She was prescribed morphine for numerous spinal fractures, which caused her a great deal of pain. On 6/14/25, she was given her scheduled morphine between 5:00 a.m. and 6:00 a.m. Around 11:00 a.m., she received other routine medications as scheduled. At approximately 5:00 p.m., she requested her scheduled morphine and was told she had received her two scheduled doses for the day. She would not get another dose until 11:00 p.m. At approximately 11:00

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

p.m., although she had a tremendous amount of pain, she declined morphine because she received other medications at bedtime which made her sleepy. She had already been given two morphine that day and was afraid to take a third, fearing she might overdose.

A progress note, dated 6/14/25 at 8:11 p.m., written by LPN 3, indicated another staff member did not document the 6:00 a.m. dose of morphine on the MAR. LPN 3 assumed the medication was overlooked and gave the resident a dose of morphine. When LPN 3 and Qualified Medication Aide (QMA) 2 were performing the narcotic count, it came to light that both had given a dose of the morphine. As soon as the mistake was discovered, the DON and the physician were notified. The physician gave a verbal order to monitor the resident. If Resident F's respirations were within normal limits, the morphine could be resumed no sooner than 11:00 p.m. that night.

During an interview with the DON on 6/27/25 at 1:23 p.m., she indicated QMA 2 gave morphine on 6/14/25 at 5:26 a.m. At 10:45 a.m., the MAR indicated the 5:00 a.m. dose had not been given, so LPN 3 gave the morphine.

During an interview with the

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

DON on 6/27/25 at 2:42 p.m., she indicated QMA 2 withdrew the morphine at 5:45 a.m., and signed out the medication on the narcotic sheet, but failed to sign the administration sheet. LPN 3 gave the morphine at 10:45 a.m. because the administration sheet indicated the 5:00 a.m. dose had not been given. Later, LPN 3 saw the 5:00 a.m. dose was initialed on the narcotic sheet, realized the medication had been given twice, and contacted the DON and the physician.

During an interview with LPN 3 on 6/27/25 at 2:58 p.m., she indicated she passed morning medications on 6/14/25 and Resident F's morphine was not initialed on the MAR. She administered morphine at that time. Later that day, when she and QMA 2 were counting the narcotics, the error was discovered. LPN 3 contacted the physician and informed the resident. Resident F decided not to take the 11:00 p.m. dose of morphine because she took trazodone (sedative) at that time and did not want to combine the two medications.

A medication administration record, dated June 2025, and provided by the DON on 6/27/25 at 11:23 a.m. indicated on 6/14/25, the 6:00 a.m. dose of morphine was initialed by LPN 3. The 6:00 p.m. dose was

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

FORM APPROVED

OMB NO. 0938-0391

marked as refused.

The MAR lacked documentation of the 10:45 a.m. dose of morphine.

Resident F's narcotic count sheet for morphine sulfate 30 mg ER indicated QMA 2 gave the resident morphine on 6/14/25 at 5:26 a.m. At 10:45 a.m., with the date 6/15/25 marked through and changed to 6/14/25, LPN 3 administered another 30 mg morphine tablet.

A current facility policy, titled "Medication Administration Policy," provided by the DON on 6/27/25 at 3:35 p.m., indicated the following: "...Administration - Medication must be documented immediately after medication administration"

This citation relates to Complaint IN00461905.

Based on record review and interview, the facility failed to ensure medication administration was documented per facility policy and accepted professional standards to prevent a resident receiving duplicate doses of a controlled pain medication for 1 of 5 residents reviewed for medication administration.
(Resident F)

Findings include:

Resident F's clinical record was

reviewed on 6/27/25 at 11:08 a.m. Diagnoses included chronic obstructive pulmonary disease (COPD), anxiety disorder, essential hypertension, hyperlipidemia, major depressive disorder, and rheumatoid arthritis.

Current physician orders, dated 6/13/25, included trazodone 100 milligrams (mg) take one tablet by mouth at bedtime and morphine sulfate extended release (ER) 30 mg take one tablet by mouth twice daily at 6:00 a.m. and 6:00 p.m.

During an interview with Resident F on 6/27/25 at 12:05 p.m., she indicated nursing had made some mistakes with the administration of her morphine. She was her own advocate, was familiar with all her medications, and knew when those medications were to be given. She was prescribed morphine for numerous spinal fractures, which caused her a great deal of pain. On 6/14/25, she was given her scheduled morphine between 5:00 a.m. and 6:00 a.m. Around 11:00 a.m., she received other routine medications as scheduled. At approximately 5:00 p.m., she requested her scheduled morphine and was told she had received her two scheduled doses for the day. She would not get another dose until 11:00 p.m. At approximately 11:00

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

p.m., although she had a tremendous amount of pain, she declined morphine because she received other medications at bedtime which made her sleepy. She had already been given two morphine that day and was afraid to take a third, fearing she might overdose.

A progress note, dated 6/14/25 at 8:11 p.m., written by LPN 3, indicated another staff member did not document the 6:00 a.m. dose of morphine on the MAR. LPN 3 assumed the medication was overlooked and gave the resident a dose of morphine. When LPN 3 and Qualified Medication Aide (QMA) 2 were performing the narcotic count, it came to light that both had given a dose of the morphine. As soon as the mistake was discovered, the DON and the physician were notified. The physician gave a verbal order to monitor the resident. If Resident F's respirations were within normal limits, the morphine could be resumed no sooner than 11:00 p.m. that night.

During an interview with the DON on 6/27/25 at 1:23 p.m., she indicated QMA 2 gave morphine on 6/14/25 at 5:26 a.m. At 10:45 a.m., the MAR indicated the 5:00 a.m. dose had not been given, so LPN 3 gave the morphine.

During an interview with the

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

DON on 6/27/25 at 2:42 p.m., she indicated QMA 2 withdrew the morphine at 5:45 a.m., and signed out the medication on the narcotic sheet, but failed to sign the administration sheet. LPN 3 gave the morphine at 10:45 a.m. because the administration sheet indicated the 5:00 a.m. dose had not been given. Later, LPN 3 saw the 5:00 a.m. dose was initialed on the narcotic sheet, realized the medication had been given twice, and contacted the DON and the physician.

During an interview with LPN 3 on 6/27/25 at 2:58 p.m., she indicated she passed morning medications on 6/14/25 and Resident F's morphine was not initialed on the MAR. She administered morphine at that time. Later that day, when she and QMA 2 were counting the narcotics, the error was discovered. LPN 3 contacted the physician and informed the resident. Resident F decided not to take the 11:00 p.m. dose of morphine because she took trazodone (sedative) at that time and did not want to combine the two medications.

A medication administration record, dated June 2025, and provided by the DON on 6/27/25 at 11:23 a.m. indicated on 6/14/25, the 6:00 a.m. dose of morphine was initialed by LPN 3. The 6:00 p.m. dose was

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

marked as refused.

The MAR lacked documentation of the 10:45 a.m. dose of morphine.

Resident F's narcotic count sheet for morphine sulfate 30 mg ER indicated QMA 2 gave the resident morphine on 6/14/25 at 5:26 a.m. At 10:45 a.m., with the date 6/15/25 marked through and changed to 6/14/25, LPN 3 administered another 30 mg morphine tablet.

A current facility policy, titled "Medication Administration Policy," provided by the DON on 6/27/25 at 3:35 p.m., indicated the following: "...Administration - Medication must be documented immediately after medication administration"

This citation relates to Complaint IN00461905.

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