STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155038	A. BUILDING 00 B. WING	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERS EDGE VILLAGE	2200 WEST WHITE RIVER BLVD MUNCIE, IN 47303

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00444118 and IN00444694. Complaint IN00444118 - Federal/state deficiencies related to the allegations are cited at F755. Complaint IN00444694 - No deficiencies related to the allegations are cited. Survey dates: October 21 & 22, 2024 Facility number: 000013 Provider number: 155038 AIM number: 100266100 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 58 Other: 2 Total: 64 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed October 24, 2024	F 0000	Neither signing nor submission of this plan of correction shall constitute an admission of any deficiency or of any fact or conclusion set forth in the "Statement of Deficiencies". This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. I would like to request Paper Compliance for this Citation. Thank You	
F 0755 SS=E Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure narcotic medication administration was documented according to policy for 3 of 3	F 0755	what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	10/23/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
James Thomas	Executive Director	11/12/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	residents (Resident A, E, and F), and that controlled substance reconciliation was complete and accurate according to facility policy for 3 of 3 medication carts, to assure medications were not diverted by a staff member. Findings include: Review of a Facility Reported Incident dated 9/26/24 at 1:20 p.m., indicated Resident A had reported she had not received her scheduled pain medication on 9/25/24 from the night nurse. Following an investigation, LPN 3 was suspended until the investigation could be completed. a. The clinical record review for Resident A was completed on 10/22/24 at 10:38 a.m. Diagnoses included schizoaffective disorder/depressive type, anxiety disorder, and chronic pain syndrome. She admitted to the facility on 3/1/24. A physician's order, dated 9/13/24, indicated to give morphine (pain medication) extended release 15 mg (milligram) every eight hours for pain. The order was discontinued on 9/18/24. A current physician's order, dated 9/18/24, indicated to give morphine extended release 30 mg, every eight hours for pain. A review of the documentation of narcotic administration indicated the following: On 9/13/24 at 5:00 a.m., an EDK (emergency drug kit) Narcotic form was completed for Morphine 15 mg extended release. A note on the form indicated the pharmacy had authorized one tablet to be removed. The form indicated two tablets were removed. The form was signed by LPN 3.		The affected residents A, E and F narcotic medication reconciliation sheets have been audited to ensure medications were administered per MD order and documented per policy how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving narcotics have the potential to be affected. An audit was completed for all residents. We compared their pharmacy deliveries to their current medication counts as well as their used or destroyed medication documentation to determine possible missing medication. Only 1 resident was found to have suspected missing medication and it was replaced prior to the survey visit. what measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; An inservice was conducted on 9/26/24 with all nurses and QMA's on proper Narcotic counting and Electronic medical record documentation. Increased auditing has been initiated to ensure compliance by the DNS/Designee.	

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	On 9/15/24 at 5:00 a.m., an entry on the narcotic medication count sheet for Resident A had an entry signed by LPN 3 that was marked out with a line through it, and the word "dropped" indicated next to her signature indicating descruction of the dropped medication. The entry lacked any other staff initials, signature, or indication of disposal. An entry below indicated another dose was removed on 9/15/24 at 6:00 am. On 9/24/24 at 5:00 a.m., entry on the narcotic medication count sheet for Resident A had an entry signed by LPN 3 that was marked out with a line. The record lacked an explanation or staff co-signature/initials. An entry below indicated another pill was removed by LPN 3 and was dated and timed 9/24/24 at 5:00 a.m. b. The clinical record review for Resident E was completed on 10/22/24 at 9:20 a.m. Diagnoses included colon cancer, malnutrition, and colostomy. The resident was admitted on 6/15/24 and was discharged to another facility on 10/7/24. A physician's order, dated 6/18/24, indicated to provide hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg, every four hours as needed for moderate to severe pain. The order was discontinued on 7/25/24. A physician order, dated 7/25/24 indicated to provide hydrocodone-acetaminophen 10-325 mg, every four hours as needed for pain. The order was discontinued on 9/23/24. A physician's order, dated 9/23/24, indicated to provide hydrocodone-acteaminophen 5-325 mg, every four hours as needed for pain. The order was discontinued on 10/7/24.		how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; A member of the nursing department leadership will audit the Narcotic count sheets and EMAR documentation 2 X daily for 2 weeks then 5 X per week for 6 weeks then 3X week for 4 weeks, then weekly for 4 weeks, then monthly spot checks thereafter. The DNS or her designee will report any discrepancies to the executive director immediately and will provide the QAPI committee with a report during each QAPI meeting. If 100% is not achieved an action plan will be implemented.	

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	On 7/19/24 at 9:00 p.m., an entry on the narcotic medication count sheet for Resident E had an entry signed by LPN 3 that was marked out with a line. The record lacked an explanation of reason for duplicate pills being obtained or staff co-signature/initials. An entry below indicated another pill was removed by LPN 3 and was dated on 7/19/24 at 9:00 p.m. On 7/28/24 at 3:30 a.m., an entry on the narcotic medication count sheet for Resident E had an entry signed by LPN 3 that was marked out with a line. The record lacked an explanation of reason for duplicate pills being obtained or staff co-signature/initials. An entry below indicated another pill was removed by LPN 3 and was dated on 7/18/24 at 3:30 a.m. On 8/24/24 at 2:30 a.m., an entry on the narcotic medication count sheet for Resident E had an entry signed by LPN 3 that was marked out with a line. The record lacked an explanation of reason for duplicate pills being obtained or staff co-signature/initials. An entry below indicated another pill was removed by LPN 3 and was dated on 8/24/24 at 2:40 a.m. c. The clinical record review for Resident F was completed on 10/22/24 at 10:05 a.m. Diagnoses included chronic kidney disease III, diabetes mellitus type II, acute respiratory failure, and depression. The resident was admitted on 12/23/23. A physician order, dated 5/24/24, indicated to provide oxycodone (pain medication) 5 mg, every four hours as needed. The order was discontinued on 7/11/24. A physician's order, dated 7/11/24, indicated to			

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	provide hydrocodone-acetaminophen 5-325 mg, every six hours as needed. On 7/19/24 at 7:00 p.m., an entry on the narcotic medication count sheet for Resident F had an entry signed by LPN 3 that was marked out with a line. The record lacked an explanation of reason for duplicate pills being obtained or staff co-signature/initials. An entry below indicated another pill was removed by LPN 3 and was dated on 7/19/24 at 7:00 p.m. On 8/24/24 at 4:30 a.m., an entry on the narcotic medication count sheet for Resident F had an entry signed by LPN 3 that was marked out with a line through it, and the word "dropped" indicated next to her signature. The record lacked a staff co-signature/initials indicating descruction of the dropped medication. An entry below indicated another pill was removed by LPN 3 and was dated on 8/24/24 at 4:30 a.m. On 9/7/24 at 3:30 a.m., an entry on the narcotic medication count sheet for Resident F had an entry signed by LPN 3 that was marked out with a line. The record lacked an explanation of reason for duplicate pills being obtained or staff co-signature/initials. An entry below indicated another pill was removed by LPN 3 and was dated on 9/7/24 at 3:30 a.m. 2. Review of the medication cart narcotic Shift Change Verification of Controlled Substances sheet, included the following: a. The West 100 hall, West 200 hall, and Memory Care unit medication carts for August 2024 lacked documentation for item count which includes number of cards, bottles, or boxes containing narcotic medications. The record lacked any			

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	additions or removals of narcotic medications. b. The West 100 hall, West 200 hall, and Memory Care unit medication carts for September 2024 lacked documentation through night shift on 9/27/24 for item count which includes number of cards, bottles, or boxes containing narcotic medications. The record lacked any additions or removals of narcotic medications through this time. During an interview on 10/22/24 at 11:38 a.m., the DON indicated the staff should have reported any incomplete or incorrect documentation entered by LPN 3 when performed the shift to shift narcotic counts. She indicated the staff were not completing the narcotic count shift to shift record appropriately and thoroughly. She has performed staff education upon completing the investigation of possible diversion of narcotic medications. She had been unable to determine an accurate count of the potential diverted narcotic medications due to poor shift to shift documentation. A current facility policy, dated 11/2015, titled, "Controlled Substances," provided by the Administrator on 10/21/24 at 2:44 p.m., included: "Policy....The staff at the Community must also maintain strict records of the controlled substances stored in the Community as well as the dose given to the resident. It is essential to make certain the resident requiring the controlled substance receives it as ordered by the physician.....Procedure...5. ...all unused medication will be destroyed with two licensed nurses and document on the medication destruction logs." A current facility policy, dated 2/1/2018, titled, "Inventory of Controlled Substances," provided by the DON on 10/22/24 at 9:10 a.m., included:			

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	"Policy: It is the policy of [provider name] to ensure that the incoming and outgoing nurses count all controlled substances at the change of each shift and document on the "Shift Change Verification of Controlled Substances" form. Procedure:...The on-coming and off-going nurse will also count the narcotic cards, boxes, and bottles to ensure accurate reconciliation. The off-going nurse will document an explanation on the "Shift Change Verification of Controlled Substance" form if there are any discrepancies or changes with the card, box, or bottle counts. If there are unexpected changes in the shift verification of controlled substances the Director of Nursing Services will be notified immediately." This Federal deficiency is related to Complaint IN00444118. 3.1- 25(b)(3)			