Dametria Marshall

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

12/29/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	COMPLETED 11/03/2023	
			_	ADDRESS OF A STATE THE SOR	11/00/2020
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD OUBLEDAY DRIVE	
WICKSH	IRE FORT HARRIS	SON		IAPOLIS, IN 46216	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` ·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG R 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
11.0000					
Bldg. 00					
		he Investigation of Complaints 419904 and IN00420121.	R 0000		
	_	6707 Residential deficiencies			
	related to the alleg and R0349.	ations are cited at R0214, R0216			
	Complaint IN0041 the allegations are	9904 No deficiencies related to cited.			
	_	0121 Residential deficiency ation is cited at R0144.			
	Survey dates: Nov	vember 2 and 3, 2023			
	Facility number: 0	14109			
	Residential Census	s: 49			
	These State Reside	ential Findings are cited in			
	accordance with 4	10 IAC 16.2-5.			
	Quality review cor	mpleted on November 9, 2023			
R 0144	410 IAC 16.2-5-1	.5(a)			
	Sanitation and Sa	afety Standards - Deficiency			
Bldg. 00		all be clean, orderly, and in			
	_	epair, both inside and out, reasonable comfort for all			
	residents.	Teasonable connoction all			
		ion, interview and record	R 0144	1. Immediate actions taken for	12/27/2023
	-	failed to maintain the		those residents.	
		ident's apartment's bathroom			.
	floor for 1 of 3 residuely cleanliness. (Residuely)	idents reviewed for facility		Housekeeping thoroughly clear	aned
	cicaminess. (Resid	ient Cj		resident apartment including bathroom floor and shampooe	ed the
	Findings include:			carpet.	
LABORATOR	Y DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

Any defiency statement 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 disclosed 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.

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 1 of 16

Executive Director

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
			B. W	ING		11/03/	/2023
		<u> </u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD	<u>I</u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹					
MICKELL	IDE EODT HADDIG	CON			OUBLEDAY DRIVE APOLIS, IN 46216		
WICKSH	IRE FORT HARRIS	DOIN		INDIAN	AFULIS, IN 402 ID		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The clinical record	of Resident C was reviewed on			2. How the facility identified ot	her	
	11-3-23 at 11:02 a.i	m. Her diagnoses included, but			residents.		
		end-stage renal failure with					
		estive heart failure, type 2			Maintenance Director and		
	diabetes with retino	pathy and high blood			housekeeping staff checked a	II	
	pressure.				occupied apartments for		
					cleanliness.		
		h Resident C on 11-2-23 at 4:15					
	-	she has had multiple			3. Measures put in place or		
	-	ies in the past year and has			systems changes.		
		tion changes related to this					
		in loose stools and sometimes			Maintenance Director and		
	_	let before beginning to stool			housekeeping staff will clean		
		floor. She indicated she has			resident apartment 5 times a		
		ues with the housekeeping			week. Clinical staff will assist	with	
		keeping staff now cleans her			light housekeeping daily as		
		ery other day now and it is so			needed.		
		oservation at this time					
	-	dark brown patches of dried			4. How the corrective action w	/III be	
		nroom floor with a slight odor			monitored.		
	of stoot present in r	Resident C's bathroom.			Fire suffice Director and		
	In an interview on	11-2-23 at 2:56 p.m., with the			Executive Director and	i+	
		ekeeping Director, he indicated			Maintenance Director will aud		
		yed at the facility approximately			housekeeping cleaning sched		
		eated Resident C is the only			for 4 weeks, then monthly for a months.	J	
		ecall who has any stooling			monus.		
		nent. "She told me she had					
	_	dure this summer that causes					
	•	ools and sometimes has a hard					
		ne toilet before she has a BM					
		So, I have the housekeeping					
		y check her apartment and					
		coom every day to make sure it					
		that I've ever noticed she					
	smells like BM or h						
	In an interview on 1	11-3-23 at 9:35 a.m., with					
		e indicated she is familiar with					
	· '		1				I

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 2 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 11/03/2023			
	ROVIDER OR SUPPLIER		8025 D	ADDRESS, CITY, STATE, ZIP COD OUBLEDAY DRIVE IAPOLIS, IN 46216	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	Resident C as the hobathroom floors threshe will have dried phave to wet it down get it cleaned up." I recall noticing any sapartment or on the A review of Resider a service plan for "Finitiated on 7-7-22, housekeeping needs goal, included, "Hot scheduled days; Thrintervention was ini on 6-8-23. In an interview on 1 Executive Director, locate a specific pol keeping the rooms cexpectation is the rekept clean. This Residential tag IN00420121. 2.5-1.5(a)	Dusekeeping staff clean her be times a week. "Sometimes, poop on the floor. So we may and let it soak to be able to Housekeeper #5 was unable to stool on other floors in her resident's clothing or shoes. In C's services plans indicated Home management," was with the goal of meeting her. Interventions to meet this asekeeping: is provided on the times weekly." This stiated on 7-7-22 and revised 1-3-23 at 2:44 p.m., with the she indicated she could not icy about housekeeping or clean. She added her sident apartments should be	TAG	DEFICIENCY	DATE
R 0214 Bldg. 00	each resident shal admission and sha semiannually and change in the resident	ency of the individual needs of I be initiated prior to all be updated at least upon a known substantial dent's condition, or more nt's or facility's request. chall evaluate the nursing			
		and record review, the facility	R 0214	1. Immediate actions taken fo	r 12/27/2023

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 3 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 11/03/2023	
	PROVIDER OR SUPPLIEF		8025 D	ADDRESS, CITY, STATE, ZIP COD OOUBLEDAY DRIVE NAPOLIS, IN 46216	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG	failed to ensure server reviewed for medic ability to self-admin of chronic pain and medications ordered management organic Findings include: The clinical record 11-2-23 at 3:17 p.m. were not limited to, failure, high blood provided above the server of	of Resident B was reviewed on . Her diagnoses included, but dementia, congestive heart pressure, peripheral vascular	TAG	those residents identified. ="" p=""> HWD reviewed and updated resident Self-Administration of Medication Review and Servic Plan. 2. How the facility identified or residents. These residents were the online residents identified.	of ice other
	disease, low back pain and cellulitis. The facility conducted a "Folstein Mini Mental Exam," on 9-25-23, which indicated the resident's cognitive abilities were within normal limits.			Measures put in place or system changes.	
	In an interview with p.m., she indicated, have some problem QMA on late evenimeds. I get oxycod don't have somebood	"They [the facility] seem to s with keeping a nurse or ngs and night shift to pass one every 6 hours. When they y scheduled, usually a QMA, 7 2 am dose, they have		Nurse or QMA will administer scheduled and as needed medications based upon the residents ability to self-admin medications per self-administration of medicar review and current physician order.	iister
	somebody get it rea to myself at 2 am. that time for so long 1:45 a.m. and have they bring my even 7:30 to 8:00 p.m."	dy and leave it with me to give Since I have been taking it at g, I usually wake up around no problem taking it. Usually, ing or bedtime meds around		4. How the corrective action of monitored. The HWD or designee will be responsible for compliance. A issues identified will be immediately advised.	•
	for Resident B was indicated Resident I medication with ass medication expirati was able to identify with assistance. It is	tion of Medications Review," conducted on 9-4-23, which B was able to identify istance, was able to identify on date with assistance and what each medication was for ndicated Resident B was fully ng when medications were to			

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 4 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	e survey pleted 3/2023
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP C	OD	
WICKSH	IRE FORT HARRIS	SON		OUBLEDAY DRIVE IAPOLIS, IN 46216		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	*	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION t dosage to be taken,	TAG	BEHREIN		DATE
		handwashing techniques				
		dication administration, how to				
	measure the correct	dosage from the medication				
	container and how t	to request any medications				
	stored at the Reside	ent Assistance Center. It				
		B was not able to demonstrate				
	_	on-controlled medication as				
	-	ng their door upon departure or				
		cation by keeping it in a locked				
		It indicated Resident B did not				
	have a physician order to self-medicate and had					
	not been granted approval to self-administer medications. It also indicated Resident B "prefers					
		ner medications." Resident B				
		by the facility as a resident who				
	self-administers her					
	5 511 WW					
	In an interview with	n the Director of Wellness				
	Services (DWS) on	11-3-23 at 11:50 a.m., she				
	indicated the facility	y does not normally staff the				
	_	arse or QMA. "So, before I got				
	-	d been having the QMA who				
		otic to get her 2 am dose ready				
	_	her apartment. I think she has				
		keeps it in. Otherwise, we do				
		he DWS added she was aware				
		elf-administration assessment acility administers her				
		OWS began employment with				
	the facility in Augu					
		,				
	The DWS indicated	l she was not aware Resident				
	B's pain medicine, o	oxycodone, was supervised by				
	_	nic. "The resident herself				
		g that to me; I couldn't find				
		rt that mentioned that." She				
	_	er, 2023, "there was an issue				
		aybe one dose of her narcotic.				
	[Name of Resident	B] will normally ask how many				

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 5 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING B. WING	00	11/03	LETED /2023
		8025 D	OUBLEDAY DRIVE		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO	ION D BE OPRIATE	(X5) COMPLETION DATE
pills she has left of lus know when her ne-ordered. She has getting low, she will get a refill while she by the pain control of happened in Septem not sure how to addimedical record] how narcotic is prescribe her regular medical. A review of Resider not address the statu of medications, her current medications, her current medication of the controlled substated for the self-administ medication during the current orders, for one 9-28-23, indicated "times a day for pain administer), 0800, 1 dose for self-administrillosse for self-admi	ner narcotic, so that she will let nedicine needs to be told me that when she is ask to be sent to the ER to e is waiting on it to be refilled clinic and that's what there. She indicated she was ress in the EMR [electronic or to identify the resident's d by a pain clinic and not by provider." In B's current service plans did as of her self-administration chronic low back pain or her orders for the routine use of ance of oxycodone, including tering of a narcotic pain the night-time hours. Her exycodone 10 milligrams, as of Give 1 tablet by mouth three (100, 2000, (Staff will prep 0200) stration)" Telates to Complaint				
Evaluation - Nonco (c) The scope and shall be delineated manual, but at a massessment shall in following: (1) The resident 's mental status.	compliance content of the evaluation d in the facility policy ninimum the needs include an evaluation of the s physical, cognitive, and				
S - Fur & & Bit rath	SUMMARY S (EACH DEFICIENCE REGULATORY OR pills she has left of It us know when her in re-ordered. She has getting low, she will get a refill while she by the pain control of happened in Septem not sure how to addi- medical record] how harcotic is prescribe ther regular medical A review of Resider not address the status of medications, her current medication of the controlled substa- for the self-administ medication during the current orders, for o 9-28-23, indicated " times a day for pain administer), 0800, 1 dose for self-admini This Residential tag IN00416707. 2.5-2(a) 410 IAC 16.2-5-2(c) Evaluation - Nonce (c) The scope and shall be delineated manual, but at a m assessment shall is following: (1) The resident's mental status.	2.5-2(a) 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident 's physical, cognitive, and	DVIDER OR SUPPLIER E FORT HARRISON SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION pills she has left of her narcotic, so that she will let us know when her medicine needs to be re-ordered. She has told me that when she is getting low, she will ask to be sent to the ER to get a refill while she is waiting on it to be refilled by the pain control clinic and that's what happened in September. She indicated she was not sure how to address in the EMR [electronic medical record] how to identify the resident's narcotic is prescribed by a pain clinic and not by her regular medical provider." A review of Resident B's current service plans did not address the status of her self-administration of medications, her chronic low back pain or her current medication orders for the routine use of the controlled substance of oxycodone, including for the self-administering of a narcotic pain medication during the night-time hours. Her current orders, for oxycodone 10 milligrams, as of 9-28-23, indicated "Give 1 tablet by mouth three times a day for pain, 0200 (resident to self administer), 0800, 1400, 2000, (Staff will prep 0200 dose for self-administration)" This Residential tag relates to Complaint IN00416707. 2.5-2(a) 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: 1) The resident's physical, cognitive, and mental status.	STREET ADDRESS, CITY, STATE, ZIP COD 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION pills she has left of her narcotic, so that she will let us know when her medicine needs to be re-ordered. She has told me that when she is getting low, she will ask to be sent to the ER to get a refill while she is waiting on it to be refilled by the pain control clinic and that's what happened in September. She indicated she was not sure how to address in the EMR [electronic medical record] how to identify the resident's narcotic is prescribed by a pain clinic and not by her regular medical provider." A review of Resident B's current service plans did not address the status of her self-administration of medications, her chronic low back pain or her current medication orders for the routine use of the controlled substance of oxycodone, including for the self-administering of a narcotic pain medication during the night-time hours. Her current orders, for oxycodone 10 milligrams, as of 9-28-23, indicated "Give 1 tablet by mouth three times a day for pain, 0200 (resident to self administer), 0800, 1400, 2000, (Staff will prep 0200 dose for self-administration)" This Residential tag relates to Complaint IN00416707. 2.5-2(a) 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the ollowing: 1) The resident's physical, cognitive, and mental status.	STREET ADDRESS, CITY, STATE, ZIP COD 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216 (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION pills she has left of her narcotic, so that she will let as know when her medicine needs to be re-ordered. She has told me that when she is getting low, she will ask to be sent to the ER to get a refill while she is waiting on it to be refilled by the pain control clinic and that's what happened in September. She indicated she was not sure how to address in the EMR [electronic medical record] how to identify the resident's narcotic is prescribed by a pain clinic and not by her regular medical provider." A review of Resident B's current service plans did not address the status of her self-administration of medications, her chronic low back pain or her current medication orders for the routine use of the controlled substance of oxycodone, including for the self-administering of a narcotic pain medication during the night-time hours. Her current orders, for oxycodone IO milligrams, as of 9-28-23, indicated "Give I tablet by mouth three times a day for pain, 0200 (resident to self administer), 0800, 1400, 2000, (Staff will prep 0200 dose for self-administration)" This Residential tag relates to Complaint N00416707. 2.5-2(a) 110 IAC 16.2-5-2(c)(1-4)(d) 2.5-2(a) 111 IAC 16.2-5-2(c)(1-4)(d) 2.5-2(a) 112 IAC 16.2-5-2(c)(1-4)(d) 2.5-2(a) 113 IAC 16.2-5-2(c)(1-4)(d) 2.5-2(a) 114 IAC 16.2-5-2(c)(1-4)(d) 2.5-2(a) 115 IAC 16.2-5-2(c)(1-4)(d) 2.5-2(a) 116 IAC 16.2-5-2(c)(1-4)(d) 3.5-2(a) 117 IAC 16.2-5-2(c)(1-4)(d) 3.5-2(a) 118 IAC 16.2-5-2(c)(1-4)(d) 3.5-2(a) 119 IAC 16.2-5-2(c)(1-4)(d) 3.5-2(a) 110 IAC 16.2-5-2(c)(1-4)(d) 3.5-2(a) 3.5-2(a) 3.5-2(a) 3.5-2(a) 3.5-2(a) 3.5-2(a) 3.5-2(a) 3.5-2(a) 3.5-2

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 6 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/03/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 8025 DOUBLEDAY DRIVE WICKSHIRE FORT HARRISON INDIANAPOLIS, IN 46216 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE activities of daily living. (3) The resident 's weight taken on admission and semiannually thereafter. (4) If applicable, the resident 's ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview and record R 0216 1. Immediate actions taken for 12/27/2023 review, the facility failed to ensure 2 of 3 residents those residents identified. identified as being unable to self-administer ="" p=""> medications did not have access to medications HWD and QMA removed all and have the ability to self-medicate. (Resident B prescription medications and OTC and C) medications from residents apartment. Findings include: 2. How the facility identified other 1. The clinical record of Resident B was reviewed residents. on 11-2-23 at 3:17 p.m. Her diagnoses included, but were not limited to, dementia, congestive heart HWD and QMA assessed all failure, high blood pressure, peripheral vascular apartments for proper medication disease, low back pain and cellulitis. The facility storage. conducted a "Folstein Mini Mental Exam," on 9-25-23, which indicated the resident's cognitive 3. Measures put in place or abilities were within normal limits. system changes. A "Self-Administration of Medications Review," Nursing staff educated to for Resident B was conducted on 9-4-23, which immediately report any indicated Resident B was able to identify medications that are not properly medication with assistance, was able to identify stored in residents apartment to medication expiration date with assistance and the HWD or Executive Director. was able to identify what each medication was for HWD and nursing staff provided with assistance. It indicated Resident B was fully residents that self-administer capable of identifying when medications were to medications a tackle box and lock be taken, the correct dosage to be taken, for medication storage. demonstrate proper handwashing techniques before and after medication administration, how to 4. How the corrective action will be measure the correct dosage from the medication monitored. container and how to request any medications stored at the Resident Assistance Center. It The HWD or designee will audit indicated Resident B was not able to demonstrate each apartment for proper

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 7 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

NT OF DEFICIENCIES OF CORRECTION	S X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER A. BUIL B. WING		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/03/2023	
PROVIDER OR SUPPLIEF		8025 D	ADDRESS, CITY, STATE, ZIP COD OUBLEDAY DRIVE IAPOLIS, IN 46216		
SUMMARY (EACH DEFICIENT REGULATORY OF Secure storage for mevidenced by locking for controlled-medications of the endications. It also staff to administer leading to administer leading to a medications. It also staff to administer leading to administer leading to a medication of the endication of the endicated leading to a medicated, have some problem QMA on late evenimeds. I get oxycood don't have somebody get it read to myself at 2 am. that time for so long 1:45 a.m. and have	SON STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION non-controlled medication as ing their door upon departure or ication by keeping it in a locked It indicated Resident B did not ider to self-medicate and had opproval to self-administer in indicated Resident B "prefers iner medications." Resident B by the facility as a resident who	8025 D	OUBLEDAY DRIVE	DATE r 4	
Services (DWS) on indicated the facilit night shift with a marked the facility has gives her 8 pm narked and she keeps it in a tacklebox that she all of her meds." The resident has a set that indicated the facility of the					

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 8 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ľ í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 11/03/	ETED
	PROVIDER OR SUPPLIEF			8025 DO	DDRESS, CITY, STATE, ZIP COD DUBLEDAY DRIVE APOLIS, IN 46216		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	2023, revealed the poxycodone was trandates 9-1-23 throug "oxycodone 10 mg, hours for pain at 02 indicated only two 9-16-23 at 2:00 p.m. A review of Reside through October, 20 receive, "oxycodona day for pain [at] 0 administer) 0800, 1 dose for self administer of a.m., dosage to acknow prepared and left we self-administer. The corresponding, was reviewed for the p.m. to 9-5-23 at 8:1 "oxycodone 10 mg, hours as needed for medication were recommedication were recommedicated every six hours at 2 8:00 p.m. and 2:00 Drug Record," for It order listed as, "oxymouth every 6 hour 9:00 p.m. through 1 records reflected the administered by face person who signed signed out the 2:00 that staff member we nor did it specify the	nt B's September 28, 2023, 223 MAR indicated she is to e 10 mg [milligrams] three times 200 (resident to self 400, 2000 (staff will prep 0200 c)." This order entry did not the person preparing the 2:00 nowledge the medication was ith the resident to later "Controlled Drug Record," e time period of 9-2-23 at 2:00 200 a.m. for the use of, take 1 tablet by mouth every 6 pain." Twelve tablets of this serived from a local emergency the medication was received 1:00 a.m., 8:00 a.m., 2:00 p.m., a.m. Subsequent "Controlled Resident B had the physician recodone 10 mg take 1 tablet by s," for the time period 9-5-23 at 1-3-23 at 2:00 p.m. These e 8:00 p.m. dose as ility staff. The same staff out the 8:00 p.m. dose also a.m. dose, but did not reflect reas signing it out at 8:00 p.m.,					

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 9 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	(x2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE (COMPL 11/03/	ETED
	PROVIDER OR SUPPLIEF		802	5 DC	DDRESS, CITY, STATE, ZIP COD DUBLEDAY DRIVE APOLIS, IN 46216		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	review of the above for 9-2-23 through doses of Resident E doses, all but 8 dos same staff person w doses. 2. The clinical reco on 11-3-23 at 11:02 but were not limited hemodialysis, cong diabetes with retino pressure. She was a resident who self-medications. A "For conducted on 7-23-cognitive impairmed Medications Review which indicated the identify medication. In an interview and 11-2-23 at 4:15 p.m were observed in R One container of a bottle without a lab attached to her wall the resident, seated appeared to be appropriated to be appropriated to the seated appeared on a small seated on a small	R LSC IDENTIFYING INFORMATION 23 "Controlled Drug Records" 11-3-23, indicated of 62 total 3's 2:00 a.m., oxycodone es were signed out by the 2'ho signed out the 8:00 p.m. ord of Resident C was reviewed 2 a.m. Her diagnoses included, 3'd to end-stage renal failure with estive heart failure, type 2 spathy and high blood not identified by the facility as administered her own olstein Mini Mental Exam," was 23 which indicated she had no nts. A "Self-Administration of av," was conducted on 7-23-23, a resident was unable to safely s due to visual deficits. observation of Resident C on an, several bottles of medication esident C's unlocked room. amber-colored pharmacy-type el was located in a basket exer, located directly in front of in her recliner. The bottle oximately three-fourths full of A second bottle of medication hall table located to the right of white bottle was labeled with	TAG				DATE
	"Sevelamer Carbon to take "3 pills 3 tir label indicated this 9-2-23 for a total of bottle having a tota Resident C indicate "are my renal potas	ate 800 mg" with instructions nes a day with meals." The was bottle 2 of 3, dispensed on £810 pills dispensed with this dispensed of 270 tablets. d both bottles of medication sium binders." (Sevelamer wn as Renvela is used to treat					

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 10 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDIN B. WING		00	COMPL 11/03/	ETED	
	PROVIDER OR SUPPLIER		802	25 DO	DDRESS, CITY, STATE, ZIP COD UBLEDAY DRIVE POLIS, IN 46216		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	kidney disease on d to explain why the r Resident B declined third bottle of medical table, but she indical some allergy medic						
	Director of Wellnes indicated she met we evening. She added give up her renal merefers to keep it in ability to make sure The DWS indicated in her room was a genedication). A reven physician orders independent of the sure of the properties of the sure of the properties of the properties of the sure of the properties	1-3-23 at 11:50 a.m., with the s Services (DWS), she ith Resident C the previous I Resident C was reluctant to edicine because she said she her room so that she has the she takes it when she eats. the other medication she had eneric for Zyrtec (an allergy iew of Resident C's current licated neither of these sted on her medication orders.					
	On 11-3-23 at 2:44 provided a copy of a "Self-Administration had an effective dat to be the current poor This policy indicate Wickshire Senior Lare competent and paself-administer their Wickshire communare competent and paself-administer their requirements are moordered by the physical authorized to prescription medical prescription medical provided in the provided to prescription medical provided in the provid	p.m., the Executive Director a policy entitled, n of Medication." This policy e of 1/2020 and was indicated licy utilized by the facility. d, "It is the policy of iving to permit residents who obysically able to r medications. 1. The ity will permit residents who					

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 11 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/03/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION l or physical ability to	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
R 0349	physician's orders of policies and procedurations does not resident to self-admof the resident's ability medications will take semi-annually."	ident non-compliance with the rethe facility's medication ures, the community shall. A resident's right to refuse of imply the ability of the inister medications. 3. Review lity to self-administer are place at a minimum						
Bldg. 00	Clinical Records - (a) The facility mu on each resident. maintained under employee of the fa responsibility. The follows: (1) Complete. (2) Accurately doo (3) Readily access (4) Systematically Based on interview failed to maintain a medication records was prepared or by administered for 1 of medications. (Resident of the clinical record of th	Noncompliance st maintain clinical records These records must be the supervision of an acility designated with that records must be as sumented. sible. organized. and record review, the facility ccurately documented to reflect when a medication whom the medication was of 3 residents reviewed for	R 0349	Immediate actions taken for those residents identified. HWD completed a Self-Administration of Medicat Review and updated clinical records for staff to administer scheduled medications. How the facility identified of residents	ion			

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 12 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/03/2023			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	disease, low back pa conducted a "Folste 9-25-23, which indi	oressure, peripheral vascular ain and cellulitis. The facility in Mini Mental Exam," on cated the resident's cognitive		This resident was the only resident identified.			
		tion of Medications Review,"		3. Measures put in place or system changes			
	indicated Resident I	conducted on 9-4-23, which 3 was able to identify istance, was able to identify		Nurse/QMA will administer all scheduled and as needed medications for this resident.			
	was able to identify with assistance. It is	what each medication was for ndicated Resident B was fully ng when medications were to		How the corrective action we monitored.	vill be		
	be taken, the correct demonstrate proper	t dosage to be taken, handwashing techniques dication administration, how to		The HWD or designee will be responsible for compliance. A issues identified will be			
	container and how t stored at the Reside	dosage from the medication o request any medications nt Assistance Center. It		immediately addressed.			
	secure storage for n evidenced by locking	3 was not able to demonstrate on-controlled medication as g their door upon departure or					
	drawer or cabinet. I have a physician or	cation by keeping it in a locked It indicated Resident B did not der to self-medicate and had					
	medications. It also staff to administer h	proval to self-administer indicated Resident B "prefers er medications." Resident B y the facility as a resident who					
	self-administers her	=					
	p.m., she indicated, have some problem QMA on late evening	"They [the facility] seem to s with keeping a nurse or ngs and night shift to pass					
	don't have somebod that can give me my	one every 6 hours. When they y scheduled, usually a QMA, 2 am dose, they have dy and leave it with me to give					

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 13 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	COMPI	(X3) DATE SURVEY COMPLETED 11/03/2023	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE FORT HARRISON			STREET ADDRESS, CITY, STATE, ZIP COD 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI		(X5) COMPLETION DATE	
me	to myself at 2 am. that time for so long 1:45 a.m. and have they bring my even 7:30 to 8:00 p.m."	Since I have been taking it at g, I usually wake up around no problem taking it. Usually, ing or bedtime meds around	TAG			DATE	
	Services (DWS) on indicated the facilit night shift with a many here, the facility has gives her 8 pm narce	the Director of Wellness 11-3-23 at 11:50 a.m., she y does not normally staff the urse or QMA. "So, before I got d been having the QMA who otic to get her 2 am dose ready her apartment. I think she has					
	a tacklebox that she all of her meds." T the resident has a so that indicated the fa medications. The I	keeps it in. Otherwise, we do the DWS added she was aware elf-administration assessment cility administers her DWS began employment with st, 2023. She indicated she					
	medical record how	address in the electronic to identify the resident's cribed by a pain clinic and not cal provider.					
	2023, revealed the poxycodone was trandates 9-1-23 throug "oxycodone 10 mg, hours for pain at 02	ord (MAR) for September, ohysician's order for the ascribed onto the MAR for h 9-28-23 at 8:00 a.m., as, 1 tablet by mouth every 6 00, 0800, 1400, 2000." The y two omissions, 9-12-23 at					
	through October, 20 receive, "oxycodon a day for pain [at] 0 administer) 0800, 1	nt B's September 28, 2023, 023 MAR indicated she is to e 10 mg [milligrams] three times 200 (resident to self 400, 2000 (staff will prep 0200)." This order entry did not					

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 14 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COMI	(X3) DATE SURVEY COMPLETED 11/03/2023	
NAME OF PROVIDER OR SUPPLIER WICKSHIRE FORT HARRISON			STREET ADDRESS, CITY, STATE, ZIP COD 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE	
TAG	reflect a means for a a.m., dosage to ack prepared and left w self-administer. The corresponding, was reviewed for the p.m. to 9-5-23 at 8:1 "oxycodone 10 mg, hours as needed for medication were record and indicated every six hours at 2 8:00 p.m. and 2:00 Drug Record," for I order listed as, "oxymouth every 6 hour 9:00 p.m. through 1 records reflected the administered by face person who signed signed out the 2:00 that staff member w nor did it specify the self-administering to review of the above for 9-2-23 through doses of Resident Edoses, all but 8 doses ame staff person who signed same staff person who signed same staff person who signed same staff person who signed out the 2 am actually signed for a a.m., on the following a.m., on the following self-administering the same staff person who signed same staff person who signed same staff person who signed out the 2 am actually signed for a a.m., on the following a.m., on the following self-administering the same staff person who signed same staff person who signed a.m., on the following a.m., on the following self-administering the same staff person who signed same staff person who signed a.m., on the following self-administering the same staff person who signed	"Controlled Drug Record," e time period of 9-2-23 at 2:00 00 a.m. for the use of, take 1 tablet by mouth every 6 pain." Twelve tablets of this evived from a local emergency the medication was received 100 a.m., 8:00 a.m., 2:00 p.m., a.m. Subsequent "Controlled Resident B had the physician recodone 10 mg take 1 tablet by s," for the time period 9-5-23 at 1-3-23 at 2:00 p.m. These e 8:00 p.m. dose as ility staff. The same staff out the 8:00 p.m. dose also a.m. dose, but did not reflect ras signing it out at 8:00 p.m., e resident was to be the medication at a later time. A 13 "Controlled Drug Records" 11-3-23, indicated of 62 total 11-3-24, indicated of 62 total 11-3-15, indicated of 62 total 11-3-16, indicated of 62 total 11-3-25, indicated of 62 total 12-3-26, indicated of 62 total 13-3-27, indicated of 62 total 14-3-28, indicated of 62 total 15-3-29, indicated of 62 total 16-3-29, indic	TAG	DEFICIENCY		DATE	
	This Residential tag	relates to Complaint					

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 15 of 16

PRINTED: 01/04/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/03/2023		
NAME OF PROVIDER OR SUPPLIER WICKSHIRE FORT HARRISON			STREET ADDRESS, CITY, STATE, ZIP COD 8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OF LSC IDENTIFYING INFORMATION	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	2.5-8.1(a)(1) 2.5-8.1(a)(2) 2.5-8.1(a)(4)						

State Form Event ID: 2F9211 Facility ID: 014109 If continuation sheet Page 16 of 16