| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00416707, IN00419904 and IN00420121.<br><br>Complaint IN00416707 -- Residential deficiencies related to the allegations are cited at R0214, R0216 and R0349.<br><br>Complaint IN00419904 -- No deficiencies related to the allegations are cited.<br><br>Complaint IN00420121 -- Residential deficiency related to the allegation is cited at R0144.<br><br>Survey dates: November 2 and 3, 2023<br><br>Facility number: 014109<br><br>Residential Census: 49<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on November 9, 2023 | R 0000 | | |
| R 0144<br><br>Bldg. 00 | 410 IAC 16.2-5-1.5(a)<br>Sanitation and Safety Standards - Deficiency<br>(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.<br>Based on observation, interview and record review, the facility failed to maintain the cleanliness of a resident's apartment's bathroom floor for 1 of 3 residents reviewed for facility cleanliness. (Resident C)<br><br>Findings include: | R 0144 | 1. Immediate actions taken for those residents.<br><br>Housekeeping thoroughly cleaned resident apartment including bathroom floor and shampooed the carpet. | 12/27/2023 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Dametria Marshall | Executive Director | 12/29/2023 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | The clinical record of Resident C was reviewed on 11-3-23 at 11:02 a.m. Her diagnoses included, but were not limited to end-stage renal failure with hemodialysis, congestive heart failure, type 2 diabetes with retinopathy and high blood pressure.<br><br>In an interview with Resident C on 11-2-23 at 4:15 p.m., she indicated she has had multiple gastrointestinal issues in the past year and has had several medication changes related to this which has resulted in loose stools and sometimes not making it to toilet before beginning to stool onto the bathroom floor. She indicated she has addressed these issues with the housekeeping staff and the housekeeping staff now cleans her bathroom about every other day now and it is so much better. An observation at this time identified multiple dark brown patches of dried material on the bathroom floor with a slight odor of stool present in Resident C's bathroom.<br><br>In an interview on 11-2-23 at 2:56 p.m., with the Maintenance/Housekeeping Director, he indicated he has been employed at the facility approximately 2 months. He indicated Resident C is the only resident he could recall who has any stooling issues in her apartment. "She told me she had some kind of procedure this summer that causes her to have loose stools and sometimes has a hard time making it to the toilet before she has a BM [bowel movement]. So, I have the housekeeping staff make sure they check her apartment and especially her bathroom every day to make sure it is clean. I can't say that I've ever noticed she smells like BM or has BM on her."<br><br>In an interview on 11-3-23 at 9:35 a.m., with Housekeeper #5, she indicated she is familiar with | | 2. How the facility identified other residents.<br><br>Maintenance Director and housekeeping staff checked all occupied apartments for cleanliness.<br><br>3. Measures put in place or systems changes.<br><br>Maintenance Director and housekeeping staff will clean resident apartment 5 times a week. Clinical staff will assist with light housekeeping daily as needed.<br><br>4. How the corrective action will be monitored.<br><br>Executive Director and Maintenance Director will audit housekeeping cleaning schedule for 4 weeks, then monthly for 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | Resident C as the housekeeping staff clean her bathroom floors three times a week. "Sometimes, she will have dried poop on the floor. So we may have to wet it down and let it soak to be able to get it cleaned up." Housekeeper #5 was unable to recall noticing any stool on other floors in her apartment or on the resident's clothing or shoes.<br><br>A review of Resident C's services plans indicated a service plan for "Home management," was initiated on 7-7-22, with the goal of meeting her housekeeping needs. Interventions to meet this goal, included, "Housekeeping: is provided on scheduled days; Three times weekly." This intervention was initiated on 7-7-22 and revised on 6-8-23.<br><br>In an interview on 11-3-23 at 2:44 p.m., with the Executive Director, she indicated she could not locate a specific policy about housekeeping or keeping the rooms clean. She added her expectation is the resident apartments should be kept clean.<br><br>This Residential tag relates to Complaint IN00420121.<br><br>2.5-1.5(a) | | | |
| R 0214<br><br>Bldg. 00 | 410 IAC 16.2-5-2(a)<br>Evaluation - Deficiency<br>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.<br>Based on interview and record review, the facility | R 0214 | 1. Immediate actions taken for | 12/27/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | failed to ensure service plans for 1 of 3 residents reviewed for medications, addressed the resident's ability to self-administer medications, her history of chronic pain and having routine narcotic medications ordered by a pain control management organization. (Resident B)<br><br>Findings include:<br><br>The clinical record of Resident B was reviewed on 11-2-23 at 3:17 p.m. Her diagnoses included, but were not limited to, dementia, congestive heart failure, high blood pressure, peripheral vascular 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.<br><br>In an interview with Resident B on 11-2-23 at 1:32 p.m., she indicated, "They [the facility] seem to have some problems with keeping a nurse or QMA on late evenings and night shift to pass meds. I get oxycodone every 6 hours. When they don't have somebody scheduled, usually a QMA, that can give me my 2 am dose, they have somebody get it ready and leave it with me to give to myself at 2 am. Since I have been taking it at that time for so long, I usually wake up around 1:45 a.m. and have no problem taking it. Usually, they bring my evening or bedtime meds around 7:30 to 8:00 p.m."<br><br>A "Self-Administration of Medications Review," for Resident B was conducted on 9-4-23, which indicated Resident B was able to identify medication with assistance, was able to identify medication expiration date with assistance and was able to identify what each medication was for with assistance. It indicated Resident B was fully capable of identifying when medications were to | | those residents identified.<br>="" p=""><br>HWD reviewed and updated resident Self-Administration of Medication Review and Service Plan.<br><br>2. How the facility identified other residents.<br><br>These residents were the only residents identified.<br><br>3. Measures put in place or system changes.<br><br>Nurse or QMA will administer all scheduled and as needed medications based upon the residents ability to self-administer medications per self-administration of medication review and current physician order.<br><br>4. How the corrective action will be monitored.<br><br>The HWD or designee will be responsible for compliance. Any issues identified will be immediately advised. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
| --- | --- |
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| --- | --- | --- | --- | --- |
| | be taken, the correct dosage to be taken, demonstrate proper handwashing techniques before and after medication administration, how to measure the correct dosage from the medication container and how to request any medications stored at the Resident Assistance Center. It indicated Resident B was not able to demonstrate secure storage for non-controlled medication as evidenced by locking their door upon departure or for controlled-medication by keeping it in a locked drawer or cabinet. 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 staff to administer her medications." Resident B was not identified by the facility as a resident who self-administers her own medications.<br><br>In an interview with the Director of Wellness Services (DWS) on 11-3-23 at 11:50 a.m., she indicated the facility does not normally staff the night shift with a nurse or QMA. "So, before I got here, the facility had been having the QMA who gives her 8 pm narcotic to get her 2 am dose ready and she keeps it in her apartment. I think she has a tacklebox that she keeps it in. Otherwise, we do all of her meds." The DWS added she was aware the resident has a self-administration assessment that indicated the facility administers her medications. The DWS began employment with the facility in August, 2023.<br><br>The DWS indicated she was not aware Resident B's pain medicine, oxycodone, was supervised by her pain control clinic. "The resident herself ended up explaining that to me; I couldn't find anything in her chart that mentioned that." She added, in September, 2023, "there was an issue with her missing maybe one dose of her narcotic. [Name of Resident B] will normally ask how many | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 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."<br><br>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)"<br><br>This Residential tag relates to Complaint IN00416707.<br><br>2.5-2(a) | | | |
| R 0216<br><br>Bldg. 00 | 410 IAC 16.2-5-2(c)(1-4)(d)<br>Evaluation - Noncompliance<br>(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:<br>(1) The resident ' s physical, cognitive, and mental status.<br>(2) The resident ' s independence in the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
| --- | --- |
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| --- | --- | --- | --- | --- |
| | activities of daily living.<br>(3) The resident ' s weight taken on admission and semiannually thereafter.<br>(4) If applicable, the resident ' s ability to self-administer medications.<br>(d) The evaluation shall be documented in writing and kept in the facility. | | | |
| | Based on observation, interview and record review, the facility failed to ensure 2 of 3 residents identified as being unable to self-administer medications did not have access to medications and have the ability to self-medicate. (Resident B and C)<br><br>Findings include:<br><br>1. The clinical record of Resident B was reviewed on 11-2-23 at 3:17 p.m. Her diagnoses included, but were not limited to, dementia, congestive heart failure, high blood pressure, peripheral vascular 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.<br><br>A "Self-Administration of Medications Review," for Resident B was conducted on 9-4-23, which indicated Resident B was able to identify medication with assistance, was able to identify medication expiration date with assistance and was able to identify what each medication was for with assistance. It indicated Resident B was fully capable of identifying when medications were to be taken, the correct dosage to be taken, demonstrate proper handwashing techniques before and after medication administration, how to measure the correct dosage from the medication container and how to request any medications stored at the Resident Assistance Center. It indicated Resident B was not able to demonstrate | R 0216 | 1. Immediate actions taken for those residents identified.<br>="" p=""><br>HWD and QMA removed all prescription medications and OTC medications from residents apartment.<br><br>2. How the facility identified other residents.<br><br>HWD and QMA assessed all apartments for proper medication storage.<br><br>3. Measures put in place or system changes.<br><br>Nursing staff educated to immediately report any medications that are not properly stored in residents apartment to the HWD or Executive Director. HWD and nursing staff provided residents that self-administer medications a tackle box and lock for medication storage.<br><br>4. How the corrective action will be monitored.<br><br>The HWD or designee will audit each apartment for proper | 12/27/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | secure storage for non-controlled medication as evidenced by locking their door upon departure or for controlled-medication by keeping it in a locked drawer or cabinet. 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 staff to administer her medications." Resident B was not identified by the facility as a resident who self-administers her own medications.<br><br>In an interview with Resident B on 11-2-23 at 1:32 p.m., she indicated, "They [the facility] seem to have some problems with keeping a nurse or QMA on late evenings and night shift to pass meds. I get oxycodone every 6 hours. When they don't have somebody scheduled, usually a QMA, that can give me my 2 am dose, they have somebody get it ready and leave it with me to give to myself at 2 am. Since I have been taking it at that time for so long, I usually wake up around 1:45 a.m. and have no problem taking it. Usually, they bring my evening or bedtime meds around 7:30 to 8:00 p.m."<br><br>In an interview with the Director of Wellness Services (DWS) on 11-3-23 at 11:50 a.m., she indicated the facility does not normally staff the night shift with a nurse or QMA. "So, before I got here, the facility had been having the QMA who gives her 8 pm narcotic to get her 2 am dose ready and she keeps it in her apartment. I think she has a tacklebox that she keeps it in. Otherwise, we do all of her meds." The DWS added she was aware the resident has a self-administration assessment that indicated the facility administers her medications. The DWS began employment with the facility in August, 2023.<br><br>A review of Resident B's Medication | | medication storage weekly for 4 weeks, the monthly for 3 months. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
| --- | --- |
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| --- | --- | --- | --- | --- |
| | Administration Record (MAR) for September, 2023, revealed the physician's order for the oxycodone was transcribed onto the MAR for dates 9-1-23 through 9-28-23 at 8:00 a.m., as, "oxycodone 10 mg, 1 tablet by mouth every 6 hours for pain at 0200, 0800, 1400, 2000. The MAR indicated only two omissions, 9-12-23 at 0200 and 9-16-23 at 2:00 p.m.<br><br>A review of Resident B's September 28, 2023, through October, 2023 MAR indicated she is to receive, "oxycodone 10 mg [milligrams] three times a day for pain [at] 0200 (resident to self administer) 0800, 1400, 2000 (staff will prep 0200 dose for self admin)." This order entry did not reflect a means for the person preparing the 2:00 a.m., dosage to acknowledge the medication was prepared and left with the resident to later self-administer.<br><br>The corresponding, "Controlled Drug Record," was reviewed for the time period of 9-2-23 at 2:00 p.m. to 9-5-23 at 8:00 a.m. for the use of, "oxycodone 10 mg, take 1 tablet by mouth every 6 hours as needed for pain." Twelve tablets of this medication were received from a local emergency room and indicated the medication was received every six hours at 2:00 a.m., 8:00 a.m., 2:00 p.m., 8:00 p.m. and 2:00 a.m. Subsequent "Controlled Drug Record," for Resident B had the physician order listed as, "oxycodone 10 mg take 1 tablet by mouth every 6 hours," for the time period 9-5-23 at 9:00 p.m. through 11-3-23 at 2:00 p.m. These records reflected the 8:00 p.m. dose as administered by facility staff. The same staff person who signed out the 8:00 p.m. dose also signed out the 2:00 a.m. dose, but did not reflect that staff member was signing it out at 8:00 p.m., nor did it specify the resident was to be self-administering the medication at a later time. A | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

review of the above 3 "Controlled Drug Records" for 9-2-23 through 11-3-23, indicated of 62 total doses of Resident B's 2:00 a.m., oxycodone doses, all but 8 doses were signed out by the same staff person who signed out the 8:00 p.m. doses.

2. The clinical record of Resident C was reviewed on 11-3-23 at 11:02 a.m. Her diagnoses included, but were not limited to end-stage renal failure with hemodialysis, congestive heart failure, type 2 diabetes with retinopathy and high blood pressure. She was not identified by the facility as a resident who self-administered her own medications. A "Folstein Mini Mental Exam," was conducted on 7-23-23 which indicated she had no cognitive impairments. A "Self-Administration of Medications Review," was conducted on 7-23-23, which indicated the resident was unable to safely identify medications due to visual deficits.

In an interview and observation of Resident C on 11-2-23 at 4:15 p.m., several bottles of medication were observed in Resident C's unlocked room. One container of a amber-colored pharmacy-type bottle without a label was located in a basket attached to her walker, located directly in front of the resident, seated in her recliner. The bottle appeared to be approximately three-fourths full of white oblong pills. A second bottle of medication was located on a small table located to the right of her recliner. This white bottle was labeled with "Sevelamer Carbonate 800 mg" with instructions to take "3 pills 3 times a day with meals." The label indicated this was bottle 2 of 3, dispensed on 9-2-23 for a total of 810 pills dispensed with this bottle having a total dispensed of 270 tablets. Resident C indicated both bottles of medication "are my renal potassium binders." (Sevelamer carbonate, also known as Renvela is used to treat

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

hyperphosphatemia in persons with chronic kidney disease on dialysis.) Resident B declined to explain why the medications were in her room. Resident B declined to allow closer inspection of a third bottle of medication located on the same table, but she indicated it was a new bottle "of some allergy medicine."

In an interview on 11-3-23 at 11:50 a.m., with the Director of Wellness Services (DWS), she indicated she met with Resident C the previous evening. She added Resident C was reluctant to give up her renal medicine because she said she prefers to keep it in her room so that she has the ability to make sure she takes it when she eats. The DWS indicated the other medication she had in her room was a generic for Zyrtec (an allergy medication). A review of Resident C's current physician orders indicated neither of these medications were listed on her medication orders.

On 11-3-23 at 2:44 p.m., the Executive Director provided a copy of a policy entitled, "Self-Administration of Medication." This policy had an effective date of 1/2020 and was indicated to be the current policy utilized by the facility. This policy indicated, "It is the policy of Wickshire Senior Living to permit residents who are competent and physically able to self-administer their medications. 1. The Wickshire community will permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration ordered by the physician or other person legally authorized to prescribe medications in North Indiana and documented in the resident's record; and (2) specific instruction for administration of prescription medications are printed on the medication labels. 2. When there is a change in

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | the resident's mental or physical ability to self-medicate or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the community shall notify the physician. A resident's right to refuse medications does not imply the ability of the resident to self-administer medications. 3. Review of the resident's ability to self-administer medications will take place at a minimum semi-annually."<br><br>This Residential tag relates to Complaint IN00416707.<br><br>2.5-2(c)(4) | | | |
| R 0349<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(a)(1-4)<br>Clinical Records - Noncompliance<br>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:<br>(1) Complete.<br>(2) Accurately documented.<br>(3) Readily accessible.<br>(4) Systematically organized.<br>Based on interview and record review, the facility failed to maintain accurately documented medication records to reflect when a medication was prepared or by whom the medication was administered for 1 of 3 residents reviewed for medications. (Resident B)<br><br>Findings include:<br><br>The clinical record of Resident B was reviewed on 11-2-23 at 3:17 p.m. Her diagnoses included, but were not limited to, dementia, congestive heart | R 0349 | 1. Immediate actions taken for those residents identified.<br><br>HWD completed a Self-Administration of Medication Review and updated clinical records for staff to administer scheduled medications.<br><br>2. How the facility identified other residents | 12/27/2023 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | failure, high blood pressure, peripheral vascular 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.<br><br>A "Self-Administration of Medications Review," for Resident B was conducted on 9-4-23, which indicated Resident B was able to identify medication with assistance, was able to identify medication expiration date with assistance and was able to identify what each medication was for with assistance. It indicated Resident B was fully capable of identifying when medications were to be taken, the correct dosage to be taken, demonstrate proper handwashing techniques before and after medication administration, how to measure the correct dosage from the medication container and how to request any medications stored at the Resident Assistance Center. It indicated Resident B was not able to demonstrate secure storage for non-controlled medication as evidenced by locking their door upon departure or for controlled-medication by keeping it in a locked drawer or cabinet. 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 staff to administer her medications." Resident B was not identified by the facility as a resident who self-administers her own medications.<br><br>In an interview with Resident B on 11-2-23 at 1:32 p.m., she indicated, "They [the facility] seem to have some problems with keeping a nurse or QMA on late evenings and night shift to pass meds. I get oxycodone every 6 hours. When they don't have somebody scheduled, usually a QMA, that can give me my 2 am dose, they have somebody get it ready and leave it with me to give | | This resident was the only resident identified.<br><br>3. Measures put in place or system changes<br><br>Nurse/QMA will administer all scheduled and as needed medications for this resident.<br><br>4. How the corrective action will be monitored.<br><br>The HWD or designee will be responsible for compliance. Any issues identified will be immediately addressed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

to myself at 2 am. Since I have been taking it at that time for so long, I usually wake up around 1:45 a.m. and have no problem taking it. Usually, they bring my evening or bedtime meds around 7:30 to 8:00 p.m."

In an interview with the Director of Wellness Services (DWS) on 11-3-23 at 11:50 a.m., she indicated the facility does not normally staff the night shift with a nurse or QMA. "So, before I got here, the facility had been having the QMA who gives her 8 pm narcotic to get her 2 am dose ready and she keeps it in her apartment. I think she has a tacklebox that she keeps it in. Otherwise, we do all of her meds." The DWS added she was aware the resident has a self-administration assessment that indicated the facility administers her medications. The DWS began employment with the facility in August, 2023. She indicated she was not sure how to address in the electronic medical record how to identify the resident's narcotic being prescribed by a pain clinic and not by her regular medical provider.

A review of Resident B's Medication Administration Record (MAR) for September, 2023, revealed the physician's order for the oxycodone was transcribed onto the MAR for dates 9-1-23 through 9-28-23 at 8:00 a.m., as, "oxycodone 10 mg, 1 tablet by mouth every 6 hours for pain at 0200, 0800, 1400, 2000." The MAR indicated only two omissions, 9-12-23 at 0200 and 9-16-23 at 2:00 p.m.

A review of Resident B's September 28, 2023, through October, 2023 MAR indicated she is to receive, "oxycodone 10 mg [milligrams] three times a day for pain [at] 0200 (resident to self administer) 0800, 1400, 2000 (staff will prep 0200 dose for self admin)." This order entry did not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

reflect a means for the person preparing the 2:00 a.m., dosage to acknowledge the medication was prepared and left with the resident to later self-administer.

The corresponding, "Controlled Drug Record," was reviewed for the time period of 9-2-23 at 2:00 p.m. to 9-5-23 at 8:00 a.m. for the use of, "oxycodone 10 mg, take 1 tablet by mouth every 6 hours as needed for pain." Twelve tablets of this medication were received from a local emergency room and indicated the medication was received every six hours at 2:00 a.m., 8:00 a.m., 2:00 p.m., 8:00 p.m. and 2:00 a.m. Subsequent "Controlled Drug Record," for Resident B had the physician order listed as, "oxycodone 10 mg take 1 tablet by mouth every 6 hours," for the time period 9-5-23 at 9:00 p.m. through 11-3-23 at 2:00 p.m. These records reflected the 8:00 p.m. dose as administered by facility staff. The same staff person who signed out the 8:00 p.m. dose also signed out the 2:00 a.m. dose, but did not reflect that staff member was signing it out at 8:00 p.m., nor did it specify the resident was to be self-administering the medication at a later time. A review of the above 3 "Controlled Drug Records" for 9-2-23 through 11-3-23, indicated of 62 total doses of Resident B's 2:00 a.m., oxycodone doses, all but 8 doses were signed out by the same staff person who signed out the 8:00 p.m. doses. The manner is which the "Controlled Drug Record," was completed appeared the staff member who signed for the 8 pm dose, then signed out the 2 am dose at/around the same time, actually signed for it, but documented it for 2:00 a.m., on the following day.

This Residential tag relates to Complaint IN416707.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 11/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| WICKSHIRE FORT HARRISON | 8025 DOUBLEDAY DRIVE<br>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 APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 2.5-8.1(a)(1)<br>2.5-8.1(a)(2)<br>2.5-8.1(a)(4) | | | |