STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS ASSISTED LIVING	10410 ALLISONVILLE ROAD FISHERS, IN 46038

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00433410. Complaint IN00433410 - State deficiencies related to the allegations are cited at R0297. Survey date: May 17, 2024 Facility number: 013039 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on May 21, 2024	R 0000		
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on interview and record review, the facility failed to ensure medications were not left in the residents' apartment to where a resident (Resident B) took the wrong medications that belonged to Resident C. Resident C received their morning medications late and Resident B was later identified with having low blood pressure and later hospitalized overnight.	R 0297	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** 1 LPN2 was provided counseling, immediate re-education of medication administration policy , and skills validation by Director of Nursing.	05/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kaitlin Buenavides	Executive Director	06/02/2024

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	Findings include: An incident reported to the Indiana State Department of Health Survey Report System, dated 4/27/24, indicated Resident B received Resident C's medications. Resident B's blood pressure was 62/43 (normal blood pressure was 120/80) and was sent out to the hospital. 1. The clinical record for Resident B was reviewed on 5/17/24 at 10:25 a.m. The diagnoses included, but were not limited to, hypertension, arthritis, and osteoporosis. A brief interview for mental status (BIMS) observation, dated 2/1/24, indicated Resident B was cognitively intact. An AL (assisted living) evaluation, dated 2/1/24, indicated Resident B needed "simple medication administration" by facility staff 1-2 times a day. Resident B had the following physician orders for 8:00 a.m. medication administration: Calcium with vitamin D & acetaminophen 500 milligrams (2 tablets) A progress note, dated 4/27/24 at 3:52 p.m., indicated the following, "...[Resident C] stating that there is an emergency. Nurse and writer informed by [Resident C] that resident [Resident B] had taken her medication by mistake. Resident's BP [blood pressure] assessed and medication list reviewed. BP was 62/44 and HR [heart rate] was 53. Writer told nurse to send resident to hospital...." A progress note, dated 4/28/24 at 4:51 p.m., indicated Resident B returned from the hospital.		2 All Nurses & Qualified Medication Assistants were re-educated on the medication administration policy on 4/30/2024. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** 1 All residents receiving medication administration services have the potential to be affected by the alleged deficient practice. 2 All nurses and QMA's completed medication administration skills validation check offs by May 6th, 2024. **What measures will be put into place or systemic changes you will make to ensure that the deficient practice does not reoccur?** 1 All nurses and QMA's were re-educated by Director of Nursing on (April 30th, 2024) regarding the medication administration policy. 2 The Director of Nursing completed medication administration skills validation check off with each nurse and QMA by May 6th, 2024. **How the corrective action(s) will be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place?**	

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	A hospital note indicated Resident B was at the hospital from 4/27/24 to 4/28/24. 2. The clinical record for Resident C was reviewed on 5/17/24 at 10:30 a.m. The diagnoses included, but were not limited to, hyponatremia, constipation, muscle weakness, repeated falls, cognitive communication deficit, edema, and hypertension. A BIMS observation, dated 2/1/24, indicated Resident C was cognitively intact. An AL evaluation, dated 3/5/24, indicated Resident C needed "simple medication administration" by facility staff 1-2 times a day. Resident C had the following physician orders for 8:00 a.m. medication administration: acetaminophen 500 milligrams extended release (2 tablets), amlodipine 5 milligrams, calcium and vitamin D, docusate sodium 100 milligrams, ferrous sulfate 325 milligrams, lisinopril-HCTZ (hydrochlorothiazide) 20-12.5 milligrams, metoprolol extended release 200 milligrams, multivitamin with minerals, & sodium chloride 1 gram. A physician order, dated 4/27/24, indicated to give the following medications for one administration: metoprolol extended release 100 milligrams, multivitamin with minerals 1 tablet, amlodipine 5 milligrams, sodium chloride 100 milligram, ferrous sulfate 325 milligrams, &		1 The Director of Nursing/ Designee will be responsible for completing a medication administration skills validation check off with each nurse or QMA responsible for administering medication upon hire. 2 The Director of Nursing/ Designee will be responsible for completing medication administration skills validation check off with each nurse or QMA responsible for administering medication at least annually. 3 QA tool has been developed for medication administration. This tool will be completed by the DON/ Designee, weekly times 4 weeks, bimonthly times 4 weeks, & then monthly until two consecutive months of compliance is maintained. 4 Pharmacy will complete medication pass audit for the month of June.	

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	lisinopril-HCTZ 20-12.5 milligrams. The physician order was dated for 4/27/24 and signed at 4:00 p.m. An interview conducted with the Director of Nursing (DON), on 5/17/24 at 10:00 a.m., indicated Licensed Practical Nurse (LPN) 2 was a newer employee to the facility but not new as a nurse. She was preparing to administer medications to Resident B and Resident C, who are a couple and lived in the same apartment. Resident C requested that LPN 2 leave the medications for Resident B and Resident C on the table in the apartment to take. An hour, or so later, Resident C called down for a nurse because she found out Resident B took the medications that were intended for Resident C. That included blood pressure medication that Resident B was not taking at that time. A nurse went to check vital signs on Resident B and his blood pressure was low. So, the emergency medical services was notified, and he was sent to the emergency room and kept at the hospital for 24 hours for observation. Since one of the medications was an extended-release medication for high blood pressure, they wanted to observe Resident B for 24 hours. We found out that Resident C did not receive their morning medications since Resident B had taken the medications belonging to Resident C. So, we obtained a one-time order for Resident C to receive their morning medications, but it wasn't conducted until 4:00 p.m. So, that was another medication error. An interview conducted with Resident B and Resident C was conducted on 5/17/24 at 11:50 a.m. Resident C indicated a nurse set two cups of medication in the apartment. Resident B went over and took what he thought was his morning			

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	medications. When Resident C went to take her morning medications, she discovered the medications in the other cup were not theirs. Resident C called for the nurse, and they went to take Resident B's vital signs. Resident B's blood pressure was "60 over something" and "that's very low". Resident B went to the hospital, and they kept him overnight. Resident B returned the following day around 4:00 p.m. The hospital kept Resident B overnight because one of the medications he took was a blood pressure medication that was an extended release. Resident B indicated he was fine after returning from the hospital but after he took the morning medications he felt "different". A policy titled "General Dose Preparation and Medication Administration", revised 6/30/23, was provided by the DON on 5/17/24 at 1:13 p.m. The policy indicated the following, "...Procedure...2.10 The community staff should not leave medications or chemicals unattended...6. Observe the resident's consumption of the medication(s)...." This citation relates to Complaint IN00433410.			