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	155291	A. BUILDING 00 B. WING	05/05/2023

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EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00406447, IN00407493, and IN00407796. Complaint IN00406447 - No deficiencies related to the allegations are cited. Complaint IN00407493 - Federal deficiencies related to the allegations are cited at F684 and F689. Complaint IN00407796 - Federal deficiencies related to the allegations are cited at F689, F690, F697, and F726. Survey dates: May 4 and 5, 2023. Facility number: 000188 Provider number: 155291 AIM number: 100266310 Census Bed Type: SNF/NF: 64 Total: 64 Census Payor Type: Medicare: 4 Medicaid: 47 Other: 13 Total: 64 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 15, 2023.	F 0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey review on or after 5/24/2023.	
F 0684 SS=D	483.25 Quality of Care			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Holder	Executive Director	05/23/2023

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.

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to honor a resident's request for a shower when staff determined the were unable to transfer a resident without a mechanical lift and failed to ensure a new bruise was charted as a non-pressure skin impairment after an allegation of being dropped during the transfer attempt for 1 of 3 residents reviewed for quality of care (Resident B). Findings include: During a confidential interview, it was indicated, Resident B was dropped during a transfer into a shower chair. Because staff were unable to get her to the shower, they gave her a bed bath instead, even though the resident requested and preferred a shower. A picture, dated 5/28/23 at 5:32 p.m., was provided. It revealed an irregular shaped bruise, purple in color, located on Resident B's right inner thigh. During an interview on 5/4/23 at 11:38 a.m., Certified Nurse Aide (CNA) 12 indicated she and another CNA went to give Resident B a shower. Once they attempted to sit her up in bed, they realized she was "too heavy," and they could not get her to the shower. They gave the resident a bed bath instead. Resident B kept asking for a shower, but CNA 12 told her she was "too	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident B no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·A 1x skin sweep round will be completed by 5/24/2023. Residents identified as having areas of alterations in skin integrity will be further reviewed to ensure assessment is put in timely. ·A 1x resident questionnaire on bathing preferences will be completed by 5/24/2023. Resident care plan will be updated accordingly to ensure resident bathing preferences are honored. ·A 1x audit of resident transfer	05/24/2023

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	heavy," and they could not get her into the chair. CNA 12 indicated it was the first time she worked with Resident B, and she was unaware what the resident's transfer status was. Since she and the other CNA could not get her up, they just gave her a bed bath instead. During the bed bath, Resident B was "ok," and let CNA 12 complete the task because she wanted to get clean. But she kept asking for a shower. CNA 12 indicated a resident's transfer status should be documented on the resident care sheet, but Resident B's status was not listed. The nurse was on break so she could not verify the resident's transfer status. During an interview on 5/4/23 at 11:45 a.m., CNA 13 indicated, another CNA had asked her to go help transfer Resident B to the shower chair. When CNAs 12 and 13 attempted to transfer Resident B, they felt she was "too heavy" and unable to stand up on her own, so they put her back in bed. CNA 12 performed a bed bath. CNA 13 indicated she had not worked with Resident B before and did not know what her transfer status was. A resident's transfer status was supposed to be on their resident care sheet, but since Resident B was not on her assignment, she did not have one. CNA 13 indicated if transfer status was not listed on the resident care sheet, then she could ask the nurse, but the nurse had been on break at the time of Resident B's bath. During an interview on 5/4//23 at 11:57 a.m., Licensed Practical Nurse (LPN) 14 indicated, on the night of Resident B's incident, he had just come back off of a break. One of the CNAs told him Resident B was complaining that she had been dropped. LPN 14 went to check on Resident B and started a skin assessment where he noted some discoloration to her inner thigh. He was unable to complete the assessment as Resident B		status will be completed by 5/24/2023 to ensure transfer status is on the resident profile. · Licensed nursing personnel will be in-serviced on or before 5/24/2023 by the DNS/designee to review the Skin Management Program, Comprehensive Care Plan, and Resident Rights policy . Education to include timely skin assessment and documentation, honoring resident bathing preferences, and transfer status. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·Licensed nursing personnel will be in-serviced on or before 5/24/2023 by the DNS/designee to review the Skin Management Program, Comprehensive Care Plan, and Resident Rights policy . Education to include timely skin assessment and documentation, honoring resident bathing preferences, and transfer status. · The wound nurse/designee will be responsible for checking the facility activity report next business day to ensure any skin alteration is being followed and monitored per facility policy. ·Activity Director or designee will utilize the 'Preferences for Daily Customary Routines' questionnaire for all new residents,	

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	began to make sexually inappropriate comments. While LPN 14 indicated he did notify the Executive Director (ED) and physician, he did not ask another nurse to complete the assessment. When asked to describe the area of discoloration, LPN 14 indicated, the area was not a bruise as he documented in the progress note, but it appeared to be more like "stretch marks." During an interview on 5/4/23 at 1:26 p.m., the ED indicated staff should honor resident's rights and preferences as long as it did not put them or the resident at risk or in danger. On 5/4/23 at 10:25 a.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood. The imbalance is caused by an illness or organs that are not working as well as they should), chronic respiratory failure and atrial fibrillation (an irregular, often rapid heartbeat). An admission Minimum Data Set (MDS) assessment, dated 3/13/23, indicated Resident B was cognitively intact but required maximum assistance or was totally dependent on staff for all her activities of daily living (ADLs). An initial assessment titled, "Preferences for Customary Routine and Activities," dated 3/13/23 at 11:16 a.m., indicated it was very important to be able to choose between a shower, bed bath or sponge bath, and she preferred to take showers. A nursing progress note, dated 3/28/23 at 8:53 p.m., indicated a CNA notified the nurse, Resident B alleged that she had been dropped from the shower chair. They "initiated" a skin assessment		quarterly, annually, and with significant change for all residents. The AD will notify the Interdisciplinary Team to update resident care plan/clinical record accordingly. ·Unit manager(s)/designee will check shower sheets daily to ensure bathing preferences are being honored. ·MDSC/designee will ensure transfer status is on the resident profile for all new residents, quarterly, annually, and with significant change. **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?** · To ensure compliance the DNS/Designee will complete an Accommodation of Needs, Skin Management Program, and Care Plan Review CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Accommodation of Needs, Skin Management Program, and Care Plan Review CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95%	

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	and no noted injuries were found. A nursing progress note dated 3/28/23 at 9:00 p.m., indicated bruising was noted to Resident B's upper right thigh and groin area, but she began to use sexually inappropriate language and the nurse was unable to complete the assessment. The record lacked documentation of a New Skin Event to document the bruise. During an interview on 5/4/23 at 1:26 p.m., the ED indicated Resident B alleged, she was dropped during a transfer from the shower chair. The ED indicated an investigation was conducted but found no evidence to support the allegation of a fall or that the resident was dropped. At that time, she provided the investigation file for review. The investigation included a "Skin Sweep Tool," conducted by LPN 14, which indicated Resident B's skin was clean, dry and intact. It did not note the bruise which was documented in the nursing progress note. Resident B's comprehensive care plans were reviewed and lacked documentation of person-centered revisions to include her transfer status, or shower preferences. Cross reference F689. On 5/5/23 at 12:12 p.m., the DHS provided a copy of current facility policy titled, "Resident Rights," revised 11/16. The policy indicated, " ...all staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, wellbeing, and proper delivery of care ...." On 5/5/23 at 12:12 p.m., the DHS provided a copy		threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	of current facility policy titled, "Skin Management," revised 5/22. The policy indicated, " ...all newly identified area after admission will be documented on the New Skin Event ...." On 5/5/23 at 12:12 p.m., the DHS provided a copy of current, but undated facility guidelines titled, "Resident Care Sheet Guidelines," which indicated " ...Resident Care Sheets will be emailed to the facility each day at 5 a.m. Date is pulled each day at 1:30 a.m. directly from the matrix care plan approaches with the "included on profile" box checked ... minimal data on the resident care sheets should include: transfer with assist of/use of ...." On 5/5/23 at 12:12 p.m., the DHS provided a copy of current facility policy titled, "IDT [interdisciplinary team] Comprehensive Care Pan Policy," revised 10/19. The policy indicated, " ...care plan problems, goals, and interventions will be updated based on changes in resident assessment/conditions, resident preferences or family input ..." This Federal tag relates to Complaint IN00407493. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices			

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	to prevent accidents. Based on observation, interview, and record review, the failed to ensure a resident was transferred by a mechanical lift as assessed by therapy for 1 of 3 residents reviewed for accidents (Resident B), facility failed to ensure fall interventions and follow up were in place for 2 of 3 residents reviewed for accidents (Residents E and F), and the facility failed to ensure medication was not left on the medication cart unsupervised around residents for 1 of 1 random observation (Residents W and M). Findings include: 1. During a confidential interview, it was indicated, Resident B was dropped during a transfer into a shower chair. A picture, dated 5/28/23 at 5:32 p.m., was provided. It revealed an irregular shaped bruise, purple in color, located on Resident B's right inner thigh. During an interview on 5/4/23 at 11:38 a.m., Certified Nurse Aide (CNA) 12 indicated she and another CNA went to give Resident B a shower. Once they attempted to sit her up in bed, they realized she was "too heavy," and they could not get her to the shower. They gave the resident a bed bath instead. Resident B kept asking for a shower, but CNA 12 told her she was "too heavy," and they could not get her into the chair. CNA 12 indicated it was the first time she worked with Resident B and she was unaware what the resident's transfer status was. Since she and the other CNA could not get her up, they just gave her a bed bath instead. During the bed bath, Resident B was "ok," and let CNA 12 complete the task because she wanted to get clean. But she kept asking for a shower. CNA 12 indicated a resident's transfer status should be documented	F 0689	**What corrective action(s) will be accomplished for those residents found to have affected by the deficient practice?** ·Resident B no longer resides at the facility. ·Resident E record includes documentation of psych referral to review medications ·Resident F fall interventions are in place and incontinence care provided per plan of care ·Resident W no longer resides at the facility **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. · DNS/designee to complete a 1x audit of resident fall care plans by 5/24/2023 to ensure interventions are in place per plan of care · A 1x audit of resident transfer status will be completed by 5/24/2023 to ensure transfer status is on the resident profile. ·A 1x resident questionnaire on bathing preferences will be completed by 5/24/2023. Resident care plan will be updated accordingly to ensure resident bathing preferences are honored. ·A 1x medication pass skills	05/24/2023

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	on the resident care sheet, but Resident B's status was not listed. The nurse was on break so she could not verify the resident's transfer status. During an interview on 5/4/23 at 11:45 a.m., CNA 13 indicated, another CNA had asked her to go help transfer Resident B to the shower chair. When CNAs 12 and 13 attempted to transfer Resident B, they felt she was "too heavy" and unable to stand up on her own, so they put her back in bed. CNA 12 performed a bed bath. CNA 13 indicated she had not worked with Resident B before and did not know what her transfer status was. A resident's transfer status was supposed to be on their resident care sheet, but since Resident B was not on her assignment, she did not have one. CNA 13 indicated if transfer status was not listed on the resident care sheet, then she could ask the nurse, but the nurse had been on break at the time of Resident B's bath. During an interview on 5/4/23 at 12:25 p.m., Occupational Therapist, (OT) 15 indicated Resident B had received therapy and while she required maximum assistance of two or more staff during therapy, the nursing staff had been educated to use a mechanical or Hoyer lift when transferring Resident B. OT 15 provided a copy of an OT progress note, dated 3/29/23, which indicated, " ...continue mechanical lift for all transfers ...." During an interview on 5/4/23 at 12:52 p.m., the Director of Nursing Services, (DNS) indicated Resident B was non-weight bearing and impulsive which made her transfer status more complicated. A resident's transfer status should be included on the resident care sheet. After the initial therapy screen, therapy recommended the transfer status, and it was added to the care sheet. The DNS		validation will be completed for all nurses/QMAs · Licensed nursing personnel will be in-serviced on or before 5/24/2023 by the DNS/designee to review the Fall Management program, Comprehensive Care Plan policy, Resident Rights policy, and medication administration procedure. Education to include honoring resident bathing preferences, transfer status, fall interventions in place, and medication administration procedure. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** · Licensed nursing personnel will be in-serviced on or before 5/24/2023 by the DNS/designee to review the Fall Management program, Comprehensive Care Plan policy, Resident Rights policy, and medication administration procedure. Education to include honoring resident bathing preferences, transfer status, fall interventions in place, and medication administration procedure. ·DNS/designee to complete rounds daily to ensure fall interventions are in place per plan of care and medication pass procedure is being followed ·Activity Director or designee will	

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	provided a copy of Resident B's care sheet which would have been current on the date of the incident, 3/27/23. The care sheet did not include her transfer status and the DNS indicated she did not know why. DNS indicated, CNAs should check the care sheet for resident needs and preferences, and if something was not included they should wait for the nurse to confirm. During an interview on 5/4/23 at 1:26 p.m., the ED indicated staff should honor resident's rights and preferences as long as it did not put them or the resident at risk or in danger. She did not know why Resident B's transfer status was not included on her care sheet. If the CNAs did not feel safe to transfer her alone, they could have waited for the nurse to confirm transfer status or help with the transfer. On 5/4/23 at 10:25 a.m., Resident B's medical record was reviewed. She had diagnoses which included, but were not limited to, metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood. The imbalance is caused by an illness or organs that are not working as well as they should), chronic respiratory failure and atrial fibrillation (an irregular, often rapid heartbeat). An admission Minimum Data Set (MDS) assessment, dated 3/13/23, indicated Resident B was cognitively intact but required maximum assistance or was totally dependent on staff for all her activities of daily living (ADLs). During an interview on 5/4/23 at 1:26 p.m., the ED indicated Resident B alleged, she was dropped during a transfer from the shower chair. The ED indicated an investigation was conducted but found no evidence to support the allegation of a		utilize the 'Preferences for Daily Customary Routines' questionnaire for all new residents, quarterly, annually, and with significant change for all residents. The AD will notify the Interdisciplinary Team to update resident care plan/clinical record accordingly. ·Unit manager(s)/designee will check shower sheets daily to ensure bathing preferences are being honored. ·MDSC/designee will ensure transfer status is on the resident profile for all new residents, quarterly, annually, and with significant change. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · To ensure compliance the DNS/Designee will complete an Accommodation of Needs, Care Plan Review, and Fall Management CQI audit tool and Medication Pass Procedure skills validation for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. Accommodation of Needs, Care Plan Review, and Fall Management CQI audit tool and Medication Pass Procedure skills	

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	fall or that the resident was dropped. At that time, she provided the investigation file for review. Resident B's comprehensive care plans were reviewed and lacked documentation of person-centered revisions to include her transfer status, or shower preferences. On 5/5/23 at 12:12 p.m., the DHS provided a copy of current, but undated facility guidelines titled, "Resident Care Sheet Guidelines," which indicated " ...Resident Care Sheets will be emailed to the facility each day at 5 a.m. Date is pulled each day at 1:30 a.m. directly from the matrix care plan approaches with the "included on profile" box checked ... minimal data on the resident care sheets should include: transfer with assist of/use of ...." On 5/5/23 at 12:12 p.m., the DHS provided a copy of current facility policy titled, "IDT [interdisciplinary team] Comprehensive Care Plan Policy," revised 10/19. The policy indicated, " ...care plan problems, goals, and interventions will be updated based on changes in resident assessment/conditions, resident preferences or family input ..." 2. On 5/5/23 at 9:30 a.m., Resident E's record was reviewed. She was a long term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, frontotemporal neurocognitive disorder, dementia, and major depressive disorder. A nursing progress note dated, 4/25/23 at 10:39 a.m., indicated Resident E had an unwitnessed fall in her room. She was noted to be on the floor and had sustained abrasions above her left eye and in the middle of her forehead.		validation will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	An Interdisciplinary (IDT) nursing progress note, dated 4/26/23 at 3:43 p.m., indicated Resident E had sustained a hematoma to her forehead and an abrasion above her left eye. A new intervention put in place to address the root cause of the fall was to have Psych review the resident's medications. [Even though Resident E's medication regimen had been reviewed 2 days prior by the pharmacist with no noted irregularities]. While Resident E's comprehensive fall risk care plan was updated on 4/26/23 to include the new intervention for medication review by Psychiatry (Psych), the record lacked documentation of the referral and/or review. On 5/5/23 at 12:32 p.m., the Director of Nursing Services (DNS) provided a copy of Resident E's most recent Psych evaluation/progress note. The note lacked documentation of Resident E's recent fall with injury, and/or a review of her medications. The DNS indicated it appeared that the intervention for psych referral to review her medications had not been completed. 3. On 5/5/23 at 10:00 a.m., Resident F's medical record was reviewed. She was a long term care resident who resided on the secured memory care unit with diagnoses which included but were not limited to, vascular dementia, lung cancer and chronic obstructive pulmonary disease (COPD). A nursing progress note, dated 4/9/23 at 4:28 p.m., indicated Resident F had an unwitnessed fall in her room. Resident F stated she "slightly hit her head of her TV stand," but no injuries were noted at that time.			

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	An IDT nursing progress note, dated 4/10/23 at 11:01 p.m., indicated a new intervention put in place to address the root cause of the fall was to encourage the resident to be in common areas. A nursing progress note, dated 4/16/23 at 6:14 a.m., indicated Resident F had another unwitnessed fall in her room. Resident F indicated she had attempted to get in her wheelchair and fell. An IDT nursing progress note, dated 4/17/23 at 10:57 a.m., indicated a new intervention to address the root cause of her fall was to apply non-skid strips to the floor beside her bed. Resident F had a comprehensive fall risk care plan dated 9/23/22. The care plan was updated to include the new interventions listed above (encourage her to common area and non-skid strip to the floor). The care plan also included, but were not limited to, additional interventions such as to have her call light within reach and to keep her pathway free of clutter. On 5/5/23 at 10:07 a.m., Resident F was observed for fall interventions. Upon entrance onto the secured memory care unit, and activity was observed to take place in the common area with several residents in attendance. Resident F was observed in her room. She laid in bed and was easily aroused to the call of her name. She wore a hospital gown and was covered by a blanket. There was a heavy smell of urine and her bedsheet, and blanket were observed to be saturated with urine. Resident F indicated, no one had come for her yet. As for her fall interventions, her call light was not within reach, as it was observed to hand down the wall in between the			

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	wall and mattress and rested on the floor under the bed. Her pathway was not free from clutter, as her wheelchair was observed directly beside the bed, as well as her overbed table, and an oxygen concentrator was beside her bed as well. She was undressed and soiled with urine, therefore, unable to be in a common area, and there were no non-skid strips installed to the floor next to her bed. During an interview on 5/5/23 at 10:17 a.m., Activity Assistant (ACT) 16 indicated Resident F was not asked to participate in activities or in the common area because she had not been gotten up for the day. ACT 16 indicated she was also a Resident Aide (RA) and was waiting to complete her CNA certification, so she often helped get Resident F ready and offered to assist her at that time. On 5/5/23 at 10:25 a.m., Resident F was observed with the DNS present. The DNS indicated that her fall interventions were not in place and indicated that was problematic since Resident F was capable and often got out of bed on her own. Secondly, the DNS indicated Resident F appeared to be soaking wet which was unacceptable since it was so late into the morning. Often there was only 1 CNA on the floor in memory care, but that day they, "had the liberty of two aides." The DNS immediately requested an aide to help get Resident F cleaned up. The DNS indicated, Resident F would often refuse help or assistance to get cleaned up, but if that was the case, she should have been notified to help with encouraging the resident to get cleaned up and/or they could try to call the family who was also very involved. On 5/5/23 at 12:12 p.m., the DHS provided a copy			

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	of current facility policy titled, "Resident Rights," revised 11/16. The policy indicated, " ...all staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, wellbeing, and proper delivery of care ...." On 5/5/23 at 12:12 p.m., the DHS provided a copy of current, but undated facility guidelines titled, "Resident Care Sheet Guidelines," which indicated " ...Resident Care Sheets will be emailed to the facility each day at 5 a.m. Date is pulled each day at 1:30 a.m. directly from the matrix care plan approaches with the "included on profile" box checked ... minimal data on the resident care sheets should include: fall interventions... safety interventions ...."4. On 5/4/23 at 4:20 p.m., Resident W was observed standing near the medication cart during medication administration. She kept pointing to the third drawer. LPN 8 opened the drawer and Resident W pointed to a plastic bag of medications. LPN 8 indicated to her it was not time for her medications. Resident W remained by the medication cart. On 5/4/23 at 4:30 p.m., LPN 8 pulled Metformin (treats type 2 diabetes) 500 milligrams (mg) for Resident M and put it into a medication cup. Then she poured 15 milliliters (mL) of Lactulose on top of the Metformin pill. She indicated it was a mistake. She pulled another Metformin 500 mg from the medication cart and placed it in a medication cup. Then, poured 15 ml of Lactulose in a separate medication cup. She closed down her computer and locked the medication cart, but left the Metformin/Lactulose mixture on top of the medication cart. She went to Resident M's room. Resident W was still by the medication cart. After providing Resident M with his medication,			

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	LPN 8 came back to the medication cart. She indicated she should not have left the Metformin/Lactulose mixture on the cart when she walked away especially with a resident with severe cognitive impairment standing next to the cart. On 5/5/23 at 12:30 pm., the Minimum Data Set Coordinator (MDSC) indicated Resident W was nonverbal and her Brief Interview for Mental Status (BIMS) for was 5, meaning the resident had severe cognitive impairment. On 5/4/23 at 4:22 p.m., the Medication Administration policy was requested from the DNS. After reviewing the policy, it did not address unattended medications. A current policy, titled, "General Dose Preparation and Medication Administration," dated 1/1/22, was provided by the DNS, on 5/5/23 at 11:41 a.m. A review of the policy indicated, " ...Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications ...." This Federal tag relates to Complaints IN00407796 and IN00407493. 3.1-14(i) 3.1-45(a)(1) 3.1-45(a)(2)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his			

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	or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, interview, and record review, the facility failed to ensure timely incontinent care was provided for 3 of 3 residents reviewed for quality of treatment (Residents G, F, and D). Findings include: 1. On 5/4/23 at 10:05 a.m., Resident G was observed in her room. She sat up in bed with her	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident G is unable to be identified in 2567 based on description. · Resident F is receiving incontinence care per plan of care	05/24/2023

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	eyes open. At that time, she was alert, engaged, and able to answer questions appropriately. Resident G indicated she had to wait a long time for assistance to go to the bathroom. Sometimes as long as 4 hours, and it had caused her to have accidents often. As she spoke, her mouth sounded dry, and she licked her lips often. Resident G indicated she was thirsty, but she tried not to drink too much because that made her have to go to the bathroom. A full bottle of water and a full Styrofoam cup of water was observed on her bedside table. 2. On 5/5/23 at 10:07 a.m., Resident F was observed in her room. She laid in bed and was easily aroused to the call of her name. She wore a hospital gown and was covered by a blanket. There was a heavy smell of urine and her bedsheet, and blanket were observed to be saturated with urine. Resident F indicated, no one had come for her yet. On 5/5/23 at 10:19 a.m., Resident F was observed with Activity Assistant 16 who indicated it appeared the resident had not been changed since the previous day. The amount of urine soaked through her brief, and the blanket that covered her made her think she had not been changed since Activity Assistant 16 changed her before leaving the day prior around 3:00 p.m. Even though Resident F would sometimes refuse certain people to help her, she had a good report with her and often helped. Activity Assistant 16 asked Resident F when she had been changed, and the resident indicated, "not since yesterday." On 5/5/23 at 10:25 a.m., Resident F was observed with the DNS present. The DNS indicated Resident F appeared to be soaking wet which was unacceptable since it was so late into the morning.		· Resident D no longer resides at the facility **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents who are incontinent of bowel/bladder have the potential to be affected by the alleged deficient practice. · A 1x audit/questionnaire completed to ensure all residents that need assistance with incontinent care is being provided per plan of care · Licensed nursing personnel will be in-serviced on or before 5/24/2023 by the DNS/designee to review the Bowel and Bladder Program. Education to include incontinence care to be provided per plan of care. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Licensed nursing personnel will be in-serviced on or before 5/24/2023 by the DNS/designee to review the Bowel and Bladder Program. Education to include incontinence care to be provided per plan of care. · DNS or designee will round daily to ensure incontinence care is being provided per plan of care. **How the corrective action(s)**	

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	Often there was only 1 CNA on the floor in memory care, but that day they, "had the liberty of two aides." The DNS immediately requested an aide to help get Resident F cleaned up. The DNS indicated, Resident F would often refuse help or assistance to get cleaned up, but if that was the case, she should have been notified to help with encouraging the resident to get cleaned up and/or they could try to call the family who was also very involved. In further review of Resident F's record, her CNA point of care (POC) charting was reviewed. On 5/5/23 at 9:43 a.m., a CNA carted, Resident F received a full shower that morning, after having received a partial bed bath even earlier that morning at 1:01 a.m. On 5/5/23 at 10:50 a.m., the DNS indicated, the CNA attempted to help get her cleaned up and she had refused so the DNS would attempt to call her family. When asked if it appeared that Resident F had been provided a shower that morning, the DNS indicated no, she was too wet, and that amount of urine did not lead her to believe she had been showered. When the POC record was reviewed with the DNS, she indicated she did not know why the aid charted a shower, but she would find out. Resident F's comprehensive care plans were reviewed, and while there were plans of care to address several behaviors concerns, none of the behaviors and/or revisions included documentation of her refusal to receive assistance with ADL and/or incontinent care. 3. During an interview, on 5/4/23 at 1:16 p.m., Resident D indicated her brief was soiled with urine and feces. About an hour ago, an unidentified Dietary Aide (DA) picked up her		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · To ensure compliance the DNS/Designee will complete a Dignity and Privacy CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Dignity and Privacy CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	lunch tray. Resident D asked her to let the nurse know she needed a pain pill and needed cleaned up from a brief soiled with urine and feces. She indicated she did not want to turn over because she did not want to press the feces onto her surgical incision. The DA indicated she would get someone to come in for the resident. On 5/4/23 at 12:27 p.m., Resident D's medical record was reviewed. Her diagnoses included, but were not limited to, lumbar spondylolisthesis (condition in which a vertebra in the lumbar spine slips forward out of position onto the bone below it) and stenosis (abnormal narrowing of the lumbar spinal canal) with neurogenic claudication (results from compression of the spinal nerves in the lumbar spine causing pain and weakness), and thoracolumbar (middle and lower back) spinal instabilities. On 4/30/23 at 3:10 p.m., Resident D was admitted to the facility via a stretcher with two emergency medical technicians (EMTs) present. Resident was able to voice all needs and concerns. She had a surgical incision to mid-back with current dressing intact. Pharmacy made aware. A current care plan, dated 5/1/23, indicated Resident D required assistance with toileting due to occasional incontinence, impaired mobility, and pain. She had a history of falling and was taking a diuretic. A staffing approach was to assist with toileting and incontinent care as needed. A Nurse Practitioner (NP) progress note, on 5/1/2023 at 8:14 a.m., indicated Resident D's hospital Magnetic Resonance Imaging (MRI) demonstrated multilevel stenosis both in the cervical (neck) spine as well as the thoracic (chest) and lumbar (lower back) spine. In the lower			

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	thoracic spine, she has a calcified disc degenerative disc changes) with spinal cord signal change (caused from chronic compression) and what appears to be the most severe stenosis. Status post (a surgical procedure that a patient has experienced previously): A transpedicular (surgical approach) discectomy (removal of the disc between vertebra) for resection (to remove all or part) of this calcified disk fragment from a bilateral (both sides approach)approach. A decompression (to relieve pressure) from T9 (thoracic vertebral body 9) down to L3 (lumbar vertebral body 3) due her multilevel stenosis and a fusion (placing bone between two bony surfaces) from T8 to the pelvis. This surgery was completed on 4/21/23, it was complicated by anemia (reduced number of red blood cells). On 5/4/23 at 11:38 a.m., the Director of Nursing Services (DNS) indicated the DA should have told a nurse about the resident's need for pain management and the nurse could have told the Certified Nursing Aide (CNA) about her being soiled. A current policy, titled, "Bowel and Bladder Program," dated 5/2019, was provided by the DNS, on 5/523 at 12:12 p.m. A review of the policy indicated, " ...If a resident is totally incontinent and unable to be placed on a toilet or bedpan, resident should be checked and changed every two hours ...." This Federal tag relates to Complaint IN00407796. 3.1-37(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management.			

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	The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, interview, and record review, the facility failed to ensure severe pain was controlled for 1 of 3 residents reviewed for pain management (Resident D). Findings include: On 5/4/34 at 1:16 p.m., Resident D indicated she arrived to the facility on 4/30/23 about 3:00 p.m.. She asked for oxycodone later in the evening and during the night because her back surgery pain was 10 on a 0 to 10 pain scale. She was not given any pain medication on 4/30/23. She indicated she finally got pain medication the next morning about 10:00 a.m. Resident D indicated her brief was soiled with urine and feces. About an hour ago, an unidentified Dietary Aide (DA) picked up her lunch tray. Resident D asked her to let the nurse know she needed a pain pill and needed cleaned up from a brief soiled with urine and feces. She indicated she did not want to turn over because she did not want to press the feces onto her surgical incision. The DA indicated she would get someone to come in for the resident. On 5/4/23 at 1:34 p.m., the Director of Nursing Services (DNS) indicated the facility had oxycodone in the Emergency Drug Kit (EDK). The facility required two facility staff nurses to be available to pull pain management narcotics from the EDK. On 4/30/23, on the evening and night shift, there was only one facility staff nurse at the facility. The other nurses were from an agency. Therefore, the facility staff nurse was unable to	F 0697	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** ·Resident D no longer resides at the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** ·All residents have the potential to be affected by the alleged deficient practice. ·A 1x audit to include interview residents to assess for pain. Any residents with pain will be addressed immediately. ·An in-service will be completed by DNS/designee 5/24/2023 for all staff to include addressing resident's complaints of pain are addressed timely. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** ·An in-service will be completed by DNS/designee for all staff to include addressing resident's	05/24/2023

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	pull pain management narcotics from the EDK for Resident D's 10 of 10 pain. She indicated she did not get a call from the evening or night nurses requesting another facility staff nurse. She indicated she could have come in to be the second facility staff nurse, so the oxycodone could have been pulled for Resident 10's severe pain. On 5/4/23 at 12:27 p.m., Resident D's medical record was reviewed. Her diagnoses included, but were not limited to, lumbar spondylolisthesis (condition in which a vertebra in the lumbar spine slips forward out of position onto the bone below it) and stenosis (abnormal narrowing of the lumbar spinal canal) with neurogenic claudication (results from compression of the spinal nerves in the lumbar spine causing pain and weakness), and thoracolumbar (middle and lower back) spinal instabilities. On 4/30/23 at 3:10 p.m., Resident D was admitted to the facility via a stretcher with two emergency medical technicians (EMTs) present. Resident D was able to voice all needs and concerns. She had a surgical incision to mid-back with current dressing intact. Pharmacy was made aware. Resident D's Medication Administration Record (MAR) indicated no medications were provided on 4/30/23. The first oxycodone was provided on 5/1/23. Her pain management medication orders, dated 4/30/23, included, but were not limited to, oxycodone (opioid pain reliever) 15 milligram (mg) tablet every 4 hours as needed for mild to moderate pain, and oxycodone 30 mg tablet every 4 hours as needed for severe pain.		complaints of pain are addressed timely. ·Care Companions to round daily to observe / report complaints of pain. If a resident complains of pain or observed to be in pain Care Companions will notify the charge nurse **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?** · To ensure compliance the DNS/Designee will complete a Pain Management CQI audit tool for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The Dignity and Privacy CQI audit tool will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	A Nurse Practitioner (NP) progress note, on 5/1/2023 at 8:14 a.m., indicated Resident D's hospital Magnetic Resonance Imaging (MRI) demonstrated multilevel stenosis both in the cervical (neck) spine as well as the thoracic (chest) and lumbar (lower back) spine. In the lower thoracic spine, she has a calcified disc degenerative disc changes) with spinal cord signal change (caused from chronic compression) and what appears to be the most severe stenosis. Status post (a surgical procedure that a patient has experienced previously): A transpedicular (surgical approach) discectomy (removal of the disc between vertebra) for resection (to remove all or part) of this calcified disk fragment from a bilateral (both sides approach)approach. A decompression (to relieve pressure) from T9 (thoracic vertebral body 9) down to L3 (lumbar vertebral body 3) due her multilevel stenosis and a fusion (placing bone between two bony surfaces) from T8 to the pelvis. This surgery was completed on 4/21/23, it was complicated by anemia (reduced number of red blood cells). On 5/5/23 at 11:36 a.m., the DNS indicated the facility staff should have called her and she could have been the second nurse to pull pain medications or they could have called another facility nurse to come in to be the second nurse to be able to pull narcotics for Resident D. The Emergency Drug Kit (EDK) policy indicated the facility required two facility staff nurses to pull narcotics from the EDK. A current policy, titled, "Pain Management Policy," dated 4/2023, was provided by the DNS, on 5/5/23 at 12:16 p.m. A review of the policy indicated, " ...It is the policy of American Senior Communities to provide the necessary care and service to attain or maintain the highest			

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	practicable physical, mental, and psychosocial wellbeing, including pain management ...Interviewable Resident - Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) ...Severe = (6-8), Very severe, horrible = (9-10) ...The physician will be notified of unrelieved or worsening pain ...Documentation of administration of ordered PRN [as needed] pain medication will be documented on the Electronic Medication Administration Record (EMAR) ... A current policy, titled, "Emergency Medication Supplies (Emergency Kits)," dated 5/1/21, was provided by the DNS, on 5/5/23 at 11:41 a.m. A review of the policy indicated, " ...The Emergency medication Supply (Emergency Kit) should be stored in known, secured, location(s) per Facility policy with immediate access only by authorized Facility personnel ...The Emergency Kit is sealed and stored in a secured area to prevent unauthorized access and to assure a proper environment for the preservation of the medication, but in such a manner to allow immediate access by authorized staff ...Doses of medication shall be administered by the same authorized nurse who removed the dose from the Emergency Kit ...Schedule III - V Controlled Substances ...In order to request authorization form Pharmacy to remove a Schedule II - V controlled substance from Facility's Controlled Substance emergency Kit, first call Pharmacy to obtain a verbal authorization ...Once Facility staff receives the authorization release from he Pharmacy. Facility staff may access the medically necessary Schedule II - V controlled substance from Facility's Emergency Medication Supply ...." A current policy, titled, "Automated Medication			

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	Dispensing Systems (AMDS)," dated 1/4/23, was provided by the DNS, on 5/5/23 at 11:41 a.m. A review of the policy indicated, " ...Per applicable law Facilities may use an AMDS to access ...emergency medications ...When a facility that has adopted a policy to have another nurse witness the removal of a controlled substance from the AMDS, but a witness is unavailable before the dose is administered, the nurse removing the dose should have a nurse on the unit or the nursing supervisor verify ...the medication ...the strength ...dosage form ...the quantity removed ...The verification by the unit nurse or supervisor should be documented in the resident's medication record ...Upon receipt of a new medication order, Facility staff should obtain the number of doses necessary to cover the period of time from the administration of the first dose until the pharmacy has processed the medication order and makes it available in the system for dispensing or delivers the medication ...Controlled substances for interim or emergency orders must be authorized by the pharmacist before removal ...." A current policy, titled, "EDK Removal: Controlled Substances," dated 2018, was provided by the DNS, on 5/5/23 at 11:41 a.m. A review of the policy indicated, " ...The Nurse: Obtains a prescription for the controlled substance and faxes it to the pharmacy ...and documents the order in the MAR. Calls pharmacy to indicated that an authorization to remove medication form the EDK is needed. The Pharmacy: Verifies that the new prescription is valid ...Provides the nurse an authorization code to withdrawal the medication via phone or fax. The Nurse (& witness): Completes all of the information on the appropriate Ekit Withdrawal Authorization Log. Removes the correct medication from the EDK.			

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	Places the yellow (bottom) copy of the Withdrawal Log in the EDK to be returned to the pharmacy ..." This Federal tag relates to Complaint IN00407796. 3.1-14(i) 3.1-37(a)			
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and			

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	techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview, and record review, the facility failed to ensure staff were competently qualified to administer physician ordered medications, to dispose of medications correctly, to secure medications and personal information, and to clean the glucometer correctly for 2 of 2 medication administration observations (Residents M, W, X, P, and S). Findings include: 1. On 5/4/23 at 4:30 p.m., Licensed Practical Nurse (LPN) 8 was preparing medication for Resident M. The physician order indicated give 22.5 milliliters (mL) Lactulose solution (laxative) 10 milligram (mg) /15 mL. She was observed pouring 15 mL in a medication cup and provided it to the resident. Resident M was observed to swallow it. On 5/4/23 at 4:40 p.m., after a conversation, LPN 8 indicated she had made a mistake with the amount of Lactulose she provided for Resident M. LPN 8 was not observed to administer the remaining Lactulose dose ordered. On 5/4/23 at 5:38 p.m., the Director of Nursing Services (DNS) indicated LPN 8 should have provided the correct dosage by double checking the order and what she dispensed into the medication cup. When her error was pointed out, she should have provided the remaining medication per the physician's order. During an interview, on 5/5/23 at 12:13 p.m., Resident M indicated he did not get any further dose of Lactulose yesterday evening.	F 0726	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident W no longer residents at the facility · Resident M is receiving medication as prescribed. **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 have the potential to be affected by the alleged deficient practice. · A 1x blood glucose cleaning skills validation will be completed for all nurses ·A 1x medication pass skills validation will be completed for all nurses · DNS/Designee to conduct an in-service with all licensed nursing staff and QMAs by 5/24/2023 regarding medication pass procedure, medication destruction, blood glucose meter cleaning/disinfecting and testing, and properly securing medication carts/personal information. **What measures will be put into place or what systemic changes will be made to**	05/24/2023

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	A current policy titled, "General Dose Preparation and Medication Administration," dated 1/1/22, was provided by the DNS on 5/5/23 at 11:41 a.m. A review of the policy indicated, " ...Facility staff should verify that the medication name and dose are correct when compared to the medication order on the medication administration record ...." A current policy, titled, "Medication Errors," dated 11/2018, was provided by the DNS on 5/5/23 at 12:12 p.m. A review of the policy indicated, " ...The DNS will be notified of the error, resident condition ...." 2a. On 5/4/23 at 4:20 p.m., Resident W was observed standing near the medication cart during medication administration. She kept pointing to the third drawer. LPN 8 opened the drawer and Resident W pointed to a plastic bag of medications. LPN 8 indicated to her it was not time for her medications. Resident W remained by the medication cart. On 5/4/23 at 4:30 p.m., LPN 8 pulled Metformin (treats type 2 diabetes) 500 mg for Resident M and put it into a medication cup. Then, she poured 15 mL of Lactulose on top of the Metformin pill. She indicated it was a mistake. She pulled another Metformin 500 mg from the medication cart and placed it in a medication cup. Then, poured 15 ml of Lactulose in a separate medication cup. She closed down her computer and locked the medication cart but left the Metformin/Lactulose mixture on top of the medication cart. She went to Resident M's room. Resident W was still by the medication cart. After providing Resident M with his medication, she came back to the medication cart. She		**ensure that the deficient practice does not recur:** · DNS/Designee to conduct an in-service with all licensed nursing staff and QMAs by 5/24/2023 regarding medication pass procedure, medication destruction, blood glucose meter cleaning/disinfecting and testing, and properly securing medication carts/personal information. · Daily observational rounds to ensure med carts are locked, HIPAA information is secure, and medication not left unattended, medication being destroyed properly using POC rounding tool by DNS/Designee. **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:** ·To ensure compliance the DNS/Designee will complete a blood glucose cleaning and medication pass skills validation for six months with audits being completed once weekly for one month, and then monthly for 5 months by a nurse manager or designee. The blood glucose cleaning and medication pass skills validation will be reviewed monthly by the CQI Committee for six months after which the CQI team will re-evaluate the continued need for the audit. If a 95% threshold is not achieved an action	

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	indicated she should not have left the Metformin/Lactulose mixture on the cart when she walked away especially with a resident with severe cognitive impairment standing next to the cart. She picked up the Metformin/Lactulose mixture and walked into a resident room near the medication cart. Resident X was in her bed and LPN 8 used her bathroom to dispose of the medication mixture. She poured the Lactulose into the resident's sink and rinsed it down, and dumped the metformin pill into the toilet and flushed it. She did not knock on Resident X's door or ask permission to enter. On 5/5/23 at 11:26 a.m., the DNS indicated once LPN 8 poured the lactulose solution on top of the Metformin pill, she should have disposed of the pill in the sharps container and poured the liquid in the toilet. On 5/5/23 at 12:23 p.m., the Assistant Director of Nursing Services (ADNS) indicated the resident who was standing by the medication cart yesterday was Resident W. She was admitted on 4/28/23 and was able to follow commands. On 5/5/23 at 12:30 pm., the Minimum Data Set Coordinator (MDSC) indicated Resident W was nonverbal and her Brief Interview for Mental Status (BIMS) for was 5, meaning the resident had severe cognitive impairment. 2b. On 5/4/23 at 4:58 p.m., LPN 8 pulled medication for Resident P. She unlocked the medication cart and unlocked the narcotic area. She put Vimpat (Schedule V Controlled Substance for seizures) 200 mg into a medication cup. She took it to Resident P's room and Resident P refused the medication. LPN 8 was observed entering		plan will be developed. Deficiency in this practice will result in disciplinary action up to and or including termination of the responsible employee.	

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	Resident X's room again. She did not knock or request entry. The Assistance Director of Nursing Services (ADNS) was with her. She indicated that with a narcotic medication disposal 2 nurses must be present. The Vimpat pill was put into Resident X toilet and flushed. On 5/4/23 at 5:40 p.m., the DNS indicated narcotics needed two nurses to dispose of it. But, for narcotics, it should have been disposed of in the Drug Buster solution (used to destroy medications). On 5/5/23 at 12:29 p.m., the ADNS indicated she should have had LPN 8 put the Vimpat in the Drug Buster solution. On 5/5/23 at 11:32 a.m., the DNS indicated the ADNS should have educated LPN 8 to use the Drug Buster solution for the narcotic and not flush it in the toilet. On 5/4/23 at 4:22 p.m., the Medication Administration policy was requested from the DNS. After reviewing the policy, it did not address unattended medications. A current policy, titled, "General Dose Preparation and Medication Administration," dated 1/1/22, was provided by the DNS, on 5/5/23 at 11:41 a.m. A review of the policy indicated, " ...Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications ...." A current policy, titled, "Controlled Substance Destruction," dated 4/18, was provided by the DNS, on 5/5/23 at 12:12 p.m. A review of the policy indicated, " ...Discontinued controls will be destroyed ...by two licensed nurses			

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	...Facility-approved commercially available drug disposal kits ...." "Disposal of Controlled Substances," (September 9, 2014) was retrieved on 5/9/2023 from the DEA (Drug Enforcement Administration) Diversion website. The guidance included, " ...The method of destruction shall be consistent with the purpose of rendering all controlled substances to a non-retrievable state in order to prevent diversion of any such substance to illicit purposes and to protect the public health and safety ...A long-term care facility may dispose of controlled substances in Schedules II, III, IV, and V on behalf of an ultimate user who resides, or has resided, at such long-term care facility by transferring those controlled substances into an authorized collection receptacle located at that long-term care facility. When disposing of such controlled substances by transferring those substances into a collection receptacle, such disposal shall occur immediately ....the DEA does not believe that "sewering" (disposal down a drain or toilet) would render a pharmaceutical controlled substance "non-retrievable ...." 3. On 5/4/23 at 4:30 p.m., LPN 8 indicated the medication cart had one glucometer (device for measuring blood sugar) for all the diabetic (blood sugar disorder) residents on the hall to share. The glucometer was kept in the top right drawer of the medication cart. The drawer was observed to be dirty, with something splashed inside it. She placed it on the top front, right corner of the medication cart. She did not clean it before taking it into Resident M's room and laying it on his over the bed table. She used the glucometer on Resident M to measure his blood sugar and laid it back on the same place on the over the bed table. She collected the glucometer and paraphernalia			

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	and left the room. Back at the medication cart, she laid the soiled glucometer back on the top front, right corner. She opened a bleach germicidal wipe and wiped it for 5 seconds and laid it back on the medication cart in the same place, soiling it again. On 5/4/23 at 5:35 p.m., LPN 8 indicated she should have cleaned the glucometer before using it and should not have laid the soiled glucometer on the resident's over the bed table. She should have cleaned the glucometer with bleach wipes for 20 seconds. On 5/5/23 at 11:25 a.m., the DNS indicated the glucometer should have been cleaned with a bleach wipe for 3 minutes and she should have laid it on a clean barrier while in the resident's room. A procedure, titled, "Blood Glucose Meter Cleaning/Disinfecting and Testing," dated 5/3032, was provided by the DNS, on 5/5/23 at 12:13 p.m. A review of the procedure indicated, " ...Place a paper towel, plastic cup, or other clean barrier on hard surface. Don gloves. Obtain germicidal wipe approved for the glucometer ...disinfecting wipe is Clorox Bleach Germicidal Wipes. Wipe entire external surface of the blood glucose meter with wipes for 3 minutes ...Place cleaned meter on paper towel, in plastic cup, or on clean barrier. Allow meter to completely dry ...Leave paper towel, plastic cup or barrier that was used to allow the cleaned meter dry. This will be used to place the used glucometer on upon returning from resident room ...Proceed to resident room with cleaned meter ...Place a clean paper towel, plastic cup, or clean barrier on a hard surface. Place cleaned glucometer on paper towel, plastic cup, or clean barrier ...Perform skin puncture by using a lancet ...Place glucometer with test strip near			

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	blood droplet, the test strip will act as a wick and absorb blood ...Wait for test results ...Exit room ...Place glucometer on paper towel, plastic cup, or other barrier that was left on medication cart ...Clean blood glucose meter after u/prior to using on next resident ... Obtain germicidal wipe approved for the glucometer ...disinfecting wipe is Clorox Bleach Germicidal Wipes ...." 4. On 5/5/23 at 10:16 a.m., Qualified Medication Aide (QMA) 9 pulled 4 medications for Resident S. He placed folic acid 1 mg (supplement), Thera-M (supplement), nicotine patch 14 mg, and hydrocodone acetaminophen (narcotic pain reliever) 5/325 mg in a medication cup. On 5/5/23 at 10:24 a.m., QMA 9 walked away from the unlocked medication cart with the computer screen still displaying Resident S' personal health information (PHI) and entered Resident S' room. He was no longer in line of sight of the medication cart. On 5/4/23 at 10:27 a.m., upon returning to the medication cart, QMA 9 indicated he should have locked the medication cart and should have closed the computer screen to conceal Resident S' PHI. On 5/5/23 at 11:33 a.m., the DNS indicated QMA 9 should have blocked or minimized the computer screen and locked his medication cart when he was away from it. On 5/4/23 at 4:22 p.m., the Medication Administration policy was requested from the DNS. After reviewing the policy, it did not address unlocked medication cart or PHI displayed.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EAGLE VALLEY MEADOWS	3017 VALLEY FARMS RD INDIANAPOLIS, IN 46214

(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
	A current policy, titled, "General Dose Preparation and Medication Administration," dated 1/1/22, was provided by the DNS, on 5/5/23 at 11:41 a.m. A review of the policy indicated, " ...Facility staff should comply with Facility policy, Applicable Law and the State Operations Manual when administering medications ...." This Federal tag relates to Complaint IN00407796. 3.1-14(i) 3.1-18(a) 3.1-25(m) 3.1-37(a) 3.1-45(a)(1) 3.1-45(a)(2)			