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	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
LEGACY LIVING LEASING JASPER, LLC	1850 WEST STATE ROAD 56 JASPER, IN 47546

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00399629. Complaint IN00399629 - Substantiated. State deficiencies related to the allegations are cited at R0242. Survey dates: January 30, February 1 & 2, 2023 Facility number: 014383 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 6, 2023.	R 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 any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request desk review in lieu of a post survey visit.	
R 0242 Bldg. 00	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on interview and record review, the facility failed to monitor a resident for adverse reactions and notify the physician following a medication error for 1 of 3 closed resident records reviewed. A resident received another resident's medications and was not monitored, nor was the resident's physician immediately notified. The resident fell and sustained a type III dens fracture (spine/neck), a nondisplaced fracture of the anterior arch of C1 (spine/neck), a fracture of the	R 0242	The corrective action for the resident who was found to have been affected by the deficient practice included a 5 rights of medication administration in-service and individual conversations regarding medication administration and medication errors completed	02/21/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Theresa Wolf	Executive Director	02/14/2023

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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	anterior inferior corner as well as the spinous process of C5 (spine/neck), and right orbital fracture (facial). (Resident B and Resident G) Finding includes: During record review on 1/30/23 at 11:45 A.M., Resident B's diagnoses included, but were not limited to, chronic heart failure, type 2 diabetes, respiratory failure, and hypertension. Resident B's level of care included, but was not limited to, resident receives medications from a Registered Nurse/Licensed Practical Nurse/Qualified Medication Aide. Resident B's service plan included but was not limited to, Resident is at risk for falls related to general age-related weakness (2/7/20) and required total care with medications (12/18/21). Resident B's nurse's notes included, but was not limited to: 11/11/22 at 11:05 P.M., Resident had fallen out of bed, hit her head, Emergency Medical Services (EMS) called, resident didn't know what happened, but was able to push call light for help, had a large hematoma across forehead, complained of neck pain, EMS was unable to get full blood pressure reading, resident was able to answer questions properly except for how she got on the floor, the DON (Director of Nursing) was called, signed by QMA 3. 11/12/22 (no time), This nurse was notified by QMA 3 on 11/11/22 at 11:05 P.M., that resident had been found on the floor beside the bed when the CNA went to answer call light, QMA 3 stated that the resident had hit her head and had large hematoma, resident also complained of neck pain,		11/14/22. QMA involved was released of QMA duties immediately after investigation complete. All residents on services for medication administration have the potential to be affected by this deficiency. The in-service dated 11/14/22 and the inservice to be complete by 2/21/23 will service as corrective action. To ensure this deficiency does not recur, facility will hold in-service to all nurses and QMAs regarding medication administration and set up, med errors, physician notifications and monitoring. A 5 question quiz will be completed by each nurse to ensure competency. In service to be complete by 2/21/23. Facility will hold in-service related to this subject every 6 months to ensure ongoing competency. Monitoring of the corrective action will take place by director of nursing or designee to audit medication pass three times per week for the first four weeks, two times per week for the next four weeks, and one time per week for the following four weeks. If non compliance remains an issue during the audits, facility will continue to monitor once weekly until facility reaches 4 consecutive weeks of full compliance.	

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	advised QMA 3 and CNA not to move resident and to call 911 to send to emergency room for evaluation and treatment. CNA stayed with resident while QMA 3 contacted 911, upon investigation QMA 3 was found to have administered medications ordered for a different resident to Resident B. QMA 3 questioned by Resident B if all medications were hers as she typically does not have that many, QMA 3 did not double check the resident record and had resident take all medications. The wrong medications included, Eliquis (anticoagulant medication) 5 mg (milligrams), Tylenol 1000 mg, Remeron (antidepressant medication) 30 mg, Effexor (antidepressant medication) 37.5 mg, metoprolol (a medication used to treat high blood pressure) 25 mg, and Ativan (antianxiety medication) 0.5 mg. Family and Medical Doctor (MD) notified of findings, signed by the DON. Resident B's Emergency Department notes from the hospital, dated 11/11/22, included, "Patient... presents to the emergency department today after falling at the nursing home. Patient states that she thinks she may have gotten an extra dose of her medicine and is unsure as to exactly what happened, but she fell and struck her face on the floor..." Emergency Department provider notes included, but were not limited to: 11/12/22 at 1:22 A.M., "...CT (Computerized Tomography) scan of the cervical spine, however, shows a type 3 displaced dens fracture. She also has fractures of the transverse processes of C5 and... C6... The patient also has a C1 anterior arch fracture. The CT scan of the facial bones shows a right orbital floor fracture as well..." 11/13/22 at 4:54 A.M., "As a late entry after the		Systemic changes will be completed no later than 2/21/23.	

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	patient had left the department, we did get a phone call from (facility name) and stated that the patient had been given Ativan and Eliquis. We did call the receiving facility and let the know that Eliquis is 1 of the medicines that she received, and that patient be aware of this as she did have a small epidural hematoma at the C2 area on the CT scan." During an interview on 2/1/23 at 2:30 P.M., the DON indicated QMA 3 knew the wrong medications were given to Resident B after looking at the medication cups in the trash. The QMA notified the DON of the medication error at the time of Resident B's fall, but did not notify earlier or notify the MD. There had been a call in that day, so QMA 3 had come in early to help cover. There were 2 cups of medications preset in the medication cart (Resident B's and Resident G's). The emergency room was notified of the drug errors at the time of transport. The facility provided a Qualified Medication Aide Position Description, titled Qualified Medication Aide, and dated 1/1/18. The description included, "The Qualified Medication Aide sets up, administers, and records certain prescribed medications for residents in the facility under the supervision of a licensed nurse... Essential Position Functions... Uses the Physician's Desk Reference or other appropriate drug reference if ever unsure of unclear as to drug being administered. Checks physician's orders against medication forms... Keeps medical records current by charting pertinent resident conditions timely and routine charting as scheduled, with co-signature by licensed nurse..." This Residential tag relates to Complaint IN00399629.			

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