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	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WYNDMOOR OF EVANSVILLE LLC	6521 GREENDALE DR EVANSVILLE, IN 47711

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00431356. Complaint IN00431356 - State deficiencies related to the allegations are cited at R00241 & R00246. Survey date: April 2, 3, 2024. Facility number: 010681 Residential Census: 85 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on April 11, 2024.	R 0000		
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview, and record review, the facility failed to ensure medications were given as ordered. A medication was given without a physician order and was not documented as given for 1 of 5 residents observed during a medication pass. Resident E was observed to receive medication on April 2, 2024 that had been discontinued on February 9, 2024. (Resident E)	R 0241	R.0241 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of	05/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jessie Hawkins	Executive Director	04/26/2024

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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	Findings include: 1. On 4/2/24 at 9:22 a.m., QMA 1 was observed to prepare and administer Resident E's medications. The medications included, but were not limited to lasix (diuretic) 20 mg oral. QMA 1 was documenting medication given on a printed MAR (Medication Administration Record) instead of the EMAR (Electronic Medication Administration Record) due to the facility was without power. On 4/3/24 at 9:48 a.m. QMA 2 indicated she did not give Resident E lasix 20 mg that morning, it was not on her current orders, when a medication is discontinued it is typically taken out of the cart and sent back to the pharmacy. QMA 2 obtained a blister pack from the medication cart that contained the furosemide (alternate name for lasix) 20 mg. The pack was observed to have 4 doses, 26 doses were missing from the packet. On 4/3/24 at 10:11 a.m., Resident E's clinical record was reviewed, diagnoses included, but were not limited to, chronic kidney disease, stage 5, essential hypertension. April 2024 physician orders were reviewed and did not include a current order for lasix 20 mg oral. Discontinued orders were reviewed and included, but were not limited to: Furosemide oral tablet 20 mg (furosemide) give 1 tablet by mouth one time a day for edema related to chronic kidney disease stage 5, order date 5/10/23, discontinued date 2/9/24. The EMAR was reviewed for February 2024. The medication was documented as given on February 1-9 2024.		correction as of May 3, 2024, and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents who were provided care by the nursing staff cited were reviewed. No negative outcomes were identified based upon the documentation review. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 100% of residents who received services by the nursing staff cited were reviewed. No negative outcomes were identified based upon the review of resident documentation and incident reports. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; The medication administration policy was reviewed with all	

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	On 4/3/24 at 10:55 a.m., the DON provided a pharmacy consolidated delivery sheet. The sheet indicated that 30 doses of furosemide 20 mg tablets were delivered to the facility on 2/9/24. On 4/3/24 at 11:22 p.m., Resident E indicated they did not know if they had been receiving Lasix 20 mg, just received a lot of medications. On 4/3/24 at 12:37 p.m., QMA 3 indicated she had no idea where the 26 lasix 20 mg pills had gone, she is usually on that cart but had not been giving the medication to Resident E, she had not pulled them from the cart because she thought they were for second shift. On 4/3/24 at 12:36 p.m., the DON indicated she could not find anything additional in Resident E's chart she could see the same thing infomration as previously reviewed. She indicated she had spoken to the staff member who is usually on that cart, the staff had indicated they had not given the medication. The DON indicated she could not offer an explanation where the 26 missing does had gone. The DON indicated the MARS that QMA 1 had used to sign out medications on 4/2/24 were not available and had probably been shredded, the medications given during the power outage should have been recorded on the EMAR after the power came back on. On 4/3/24 at 1:00 p.m., the Administrator indicated it was a medication error, she assumed the staff had been giving Resident E the discontinued medication and had not been signing it out on the EMAR. On 4/3/24 at 1:17 p.m., a service plan was reviewed for Resident E and indicated A/O able to		nursing personnel that are responsible for passing medication. The seven rights of medication administration were reviewed with all nurse's and qma's. Medication Administration review class conducted by consulting RN consisting of pre/posttest and review. Initiated scheduling medication pass audit with education nurse from pharmacy. How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Health and Wellness Director or designee will audit 100% of all medication carts weekly for the first 30 days. The Health and Wellness Director will review 50% of all medication carts for days 31-60. The Health and Wellness Director or designee will review 25% of all medication carts for the days 61-90. We will review the medication administration policy and seven rights of medication administration each month at the all-staff meeting.	

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	make needs/wants known offer encourage/reminders PRN (as needed). On 4/3/24 at 12:52 p.m., the Administrator provided the current policy for medication & treatment assistance with a revision date of 3/29/20. The policy included, but was not limited to...3. Medication assistance and administration should be in accordance with the prescriber's orders... On 4/3/24 at 1:13 p.m., the Administrator provided a policy for medication administration record with a revision date of 3/29/20. The policy included, but was not limited to...a. All associates administering medications must initial the the MAR after the medication is received/taken and consumed by the resident. Explanations for medication refusal and/or not given should be documented. noted on the back of the paper MAR...4. For electronic MAR systems : 4. a. After the medication is received and consumed by the resident, the associate will document the "Administered" chart code that reflects that the medication was taken. If the medication is refused or not given/taken, the associate will document the appropriate chart code in the administration details that reflects the refusal or reason the medication was not given/taken...7. Documentation for PRN medications shall include a. symptoms for which medication was given, b. Exact dosage given, c. Response of the resident to the prn medication. This citation relates to Complaint IN00431356.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by			

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	a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview, observation and record review the facility failed get authorization by a licensed nurse or physician for PRN (as needed) medications prior to the administration for 2 of 2 residents receiving senna in a sample of 5 residents observed for medications. Two residents received medications without asking for them and the staff member did not consult with a licensed nurse or physician prior to the administration. (Residents B & C) Findings include: 1. On 4/2/24 at 9:12 a.m., QMA 1 was observed to prepare and administer Resident C's medications. The medications included, but were not limited to, senna oral tablet 8.6 mg (milligram), (stimulant laxative). The medication blister pack that contained the medication, indicated give 1 tablet two times a day related to constipation. QMA 1 was documenting medication given on a printed MAR (Medication Administration Record) instead of the EMAR (Electronic Medication Administration Record) due to the facility was without power. On 4/2/24 at 12:46 p.m., Resident C's clinical record was reviewed. Diagnoses included, but were not limited to, constipation, unspecified, chronic	R 0246	R.0246 This Plan of Correction is neither an agreement with nor an admission of wrongdoing by this facility or its staff members. Rather, it is submitted for compliance purposes. This facility alleges substantial compliance with this plan of correction as of May 3, 2024 and requests paper compliance for this survey. What corrective action will be accomplished for those residents found to have been affected by the deficient practice; Residents who were provided care by the QMA cited were reviewed. No negative outcomes were identified based upon the documentation review. How the facility will identify other	05/03/2024

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	kidney disease stage 3B. April 2024 physician orders were reviewed and included, but were not limited to: Senokot oral tablet (sennosides) give 1 tablet by mouth every 12 hours as needed for constipation, order date 3/21/24. The EMAR (electronic medication administration record) was reviewed for April 2024 and the medication was not documented as given on 4/2/24. On 4/3/24 at 10:07 a.m., Resident C indicated she did not remember asking for a stool softener yesterday. On 4/3/24 at 1:00 p.m., a service plan was reviewed for Resident C and indicated zero memory deficit or dx (diagnosis) A/O (alert and oriented) able to make needs/wants known. 2. On 4/2/24 at 9:58 a.m., QMA 1 was observed to prepare and administer Resident B's medications. The medications included, but were not limited to, senna oral tablet 8.6 mg (stimulant laxative) . QMA 1 was documenting medication given on a printed MAR (Medication Administration Record) instead of the EMAR (Electronic Medication Administration Record) due to the facility was without power. On 4/2/24 at 10:57 a.m., Resident B's clinical record was reviewed. Diagnoses included, but were not limited to, essential hypertension, chronic kidney disease stage. April 2024 physician orders were reviewed and included, but were not limited to: Senna oral 8.6 mg (Sennosides) give one tablet by		residents having the potential to be affected by the same deficient practice and what corrective action will be taken; 100% of residents who received services by the QMA cited were reviewed. No negative outcomes were identified based upon the review of resident documentation and incident reports. What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur; The QMA scope of practice was reviewed with nurses and QMAs on staff to educate them on the limitations of the QMA scope, as well as the need for documentation by a nurse for PRN authorization and administration immediately. A binder with PRN documentation sheets for each resident to have the nurse physical signature at time of authorization being given to QMA for administration placed on each cart. Medication Administration review class conducted by consulting RN consisting of pre/posttest and review. Initiated scheduling medication pass audit with education nurse from pharmacy.	

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	mouth every 12 hours as needed for constipation, order date 1/22/24. The EMAR (electronic medication administration record) was reviewed for April 2024 and the medication was not documented as given on 4/2/24. On 4/3/24 at 10:33 a.m., Resident B indicated she had not asked for her stool softener on 4/2/24, she had not been needing it. On 4/3/24 at 1:15 p.m., a service plan was reviewed for Resident B and indicated A/O x 4, able to make needs/wants known. On 4/3/24 at 1:13 p.m., the Administrator provided a policy for medication administration record with a revision date of 3/29/20. The policy included, but was not limited to...a. All associates administering medications must initial the the MAR after the medication is received/taken and consumed by the resident. Explanations for medication refusal and/or not given should be documented. noted on the back of the paper MAR...4. For electronic MAR systems : 4. a. After the medication is received and consumed by the resident, the associate will document the "Administered" chart code that reflects that the medication was taken. If the medication is refused or not given/taken, the associate will document the appropriate chart code in the administration details that reflects the refusal or reason the medication was not given/taken...7. Documentation for PRN medications shall include a. symptoms for which medication was given, b. Exact dosage given, c. Response of the resident to the prn medication.		How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and The Health and Wellness Director or designee will review 100% of all PRN medication and treatment administrations by QMA's for 30 days. The Health and Wellness Director will review 50% of all PRN medication and treatment administrations by QMA's for days 31-60. The Health and Wellness Director or designee will review 25% of all PRN medication and treatment administrations by QMA's for the days 61-90.	

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