STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF EDISON LAKES	1025 PARK PLACE MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00434184. Complaint IN00434184 - State deficiencies related to the allegations are cited at R0090, R0243 and R0246. Survey date: May 13, 14 & 15, 2024 Facility number: 013331 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 5/20/2024	R 0000	*Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.*	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robyn L Challinor	Executive Director	06/03/2024

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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	(A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on interview and record review, the facility failed to thoroughly investigate and report missing narcotic medication for 1 of 3 residents reviewed for medication use. (Resident B) Finding includes:	R 0090	The Executive Director (ED) and Director of Nursing (DON) completed re-education on 05/14/2024 and again 5/28/24 regarding Cedarhurst communication expectation policy	06/14/2024

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	On 5/13/24 at 1:37 P.M., the clinical record for Resident B was reviewed. Diagnoses included, but were not limited to: included hypertension and arthritis. Resident B also received Hospice services for diagnoses of heart failure and heart block. The Physician's Orders for Resident B included the following: - Morphine Sulfate Solution 100 mg per 5 ml (100/5 ml), to take 0.25 ml by mouth every 4 hours as needed, dated 4/45/24. - Morphine 20 mg/ml oral concentrate, take 0.25 ml by mouth daily at bedtime for terminal restlessness/anxiety, dated 5/1/24. - Morphine 20 mg/ml, to give 0.25 ml by mouth every 2 hours and every 2 hours as needed, dated 5/2/24. Resident B's Medication Administration record from 4/25/24 to 5/2/24 indicated the resident was administered morphine on the following dates and times: 4/25/24 at 9:43 P.M. 5/1/24 at 8:00 P.M. 5/1/24 at 12:09 A.M. 5/2/24 at 8:00 A.M. 5/2/24 at 12:00 P.M. A Nursing Progress Notes for Resident B, indicated morphine was administered on 5/2/24 at 12:00 P.M. per Hospice instructions. Resident B's "CONTROLLED DRUG REPORT RECORD/DISPOSITION FORM," from 4/24/24 to 5/2/24, indicated morphine was administered on the follow dates and times, and the count (amount recorded of medication left in the cart at the end of each shift) was documented as follows: 4/24/24 at 2:30 P.M., 30 ml of morphine sulfate		and procedures and Indiana State Department of Health long term care abuse and incident reporting policy. All staff re-educated on communication expectation policy and procedures to be completed by 6/14/24 that include any event or suspected event that occurs in the community will be reported to the ED and DON immediately so an investigation can be completed as per Cedarhurst policy and State regulations. All residents had the potential to be affected by this deficient practice. DON and ED will review any alleged, suspected, or actual unusual events on our daily connect. DON and ED will follow Cedarhurst communication expectation policy and IDOH policy for incident reporting. /b> Monitoring will be on-going.	

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	solution 100/5 ml, was received. 4/24/24 at 3:22 (does not document A.M. or P.M.), Employee (E) 8 signed out 0.25 ml as given with 29.75 ml remaining 4/24/24 at 9:30 (does not document A.M. or P.M.), E10 signed out 0.25 ml as given with 29.50 ml remaining 4/25/24 at 10:57 A.M., E5 signed out 0.25 ml as given with 29.25 ml remaining 4/25/24 at 9:30 P.M., E2 signed out 0.25 ml as given with 29.00 ml remaining 4/27/24 at 9:30 P.M., E2 signed out 0.25 ml as given with 28.75 ml remaining 4/28/24 at 9:30 P.M., E2 signed out 0.25 ml as given with 28.50 ml remaining 5/1/24 at 12:00 A.M., E9 signed out 0.25 ml as given with 28.25 ml remaining 5/1/24 at 9:00 P.M., E5 signed out 0.25 ml as given with 28.00 ml remaining 5/2/24 at 8:00 A.M. E2 signed out 0.25 ml as given with 24.00 ml remaining 5/2/24 No time documented, count corrected signed by Interim Director of Nursing 5/2/24 at 12:00 P.M., E3 signed out 0.25 ml as given with 23.75 ml remaining 5/2/24 at 2:35 P.M., E6 signed out 0.25 ml as given with 23.50 ml remaining 5/2/24 at 3:40 P.M. E6 signed out 0.25 ml as given with 23.25 ml remaining 5/2/24 at 5:20 P.M. E6 signed our 0.25 ml as given with 23.00 ml remaining 5/2/24, Disposition of Remaining Doses, Doses flushed Quantity: 23 ml signed by E11 and Hospice Nurse. During an interview on 5/14/24 at 1:15 P.M. with Employee 2 he indicated on 5/1/24 at 8:00 A.M., as he was going off night shift, he counted narcotics with E6 ,who was the on-coming day shift nurse. He indicated Resident B's morphine amount was			

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	"off." He indicated he notified the Interim Director on Nursing there were 4 ml of morphine solution unaccounted for, so she came to the facility to look into it. Employee 2 indicated he went home before the Interim Director of Nursing arrived to the facility and he gave E6 the medication cart keys. During an interview, on 5/14/24 at 1:41 P.M. E3 indicated E2 and E6 counted Resident B's narcotics on 5/2/24 at 8:00 A.M., and E6 notified her the morphine count was "off" for Resident B. E3 indicated she notified the Interim Director of Nursing the morphine count was not correct, but did not notify the Administrator. During an interview, on 5/14/24 at 9:45 A.M. the Administrator indicated she was not notified and was not aware of the concern with Resident B's morphine count or any medication was unaccounted for until 5/14/24 at 9:45 A.M. The Administrator indicated none of the staff notified her the morphine count for Resident B was not correct on 5/1/24. She indicated if she would have known there was morphine unaccounted for in the facility, she would have started an immediate investigation, and if necessary, would have reported the incident to the State Agency per the facility's policy for an unusual occurrence. During an interview, on 5/15/24 at 9:55 A.M. with the Interim Director of Nursing she indicated she was notified on 5/2/24 in the morning that Resident B's morphine count sheet was incorrect. She reviewed the Controlled Drug Reference Record/Disposition Form and noted on 5/2/24 at 8:00 A.M., the amount of remaining morphine was incorrect with 4 ml of morphine unaccounted for on the form.. When she looked back through the notes and report record/ disposition form, she			

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	figured the resident was "probably" receiving the morphine every 4 hours and it was not being recorded (on the Controlled Drug Reference Record/Disposition Form) every time it was administered. She also indicated she had to account for "possible spillage" and so the count of 24 ml remaining in the bottle was "likely" correct. The Interim Director of Nursing indicated she did not suspect any diversion and did not notify the Administrator because she felt she had accounted for all the doses since not all administrations were documented. On 5/15/24 at 1:20 P.M., a policy titled, "Communication Expectations Policy & Procedures," dated 7/23, was provided by the Administration who indicate it was the facility's current policy. The policy indicated,"...[The facility] must be notified of unusual occurrences that affect the operations of a community in a timely manner. When an unusual event occurs at the community, all staff members, including department heads must report the occurrence to the appropriate department head...Unusual happening or high-risk event...missing narcotics... [report to Administrator and Director of Nursing]..." This citation relates to Complaint IN00434184			
R 0243 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person			

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	administering the drug or treatment. Based on interview and record review, the facility failed to ensured medication administrations for PRN (as needed) medications were documented accurately and consistently in the Electronic Medication Record (EMR). The facility also failed to ensure PRN medication was prepared and administered by the same nurse, for 1 of 3 residents reviewed for PRN medication administration. (Resident B). Finding includes: On 5/13/24 at 1:37 P.M., the clinical record for Resident B was reviewed. Diagnoses included but were not limited to: hypertension and arthritis. Resident B was also receiving Hospice Care with diagnoses including, but not limited to: heart failure, heart block and shortness of breath. The Physician's Orders for Resident B included the following: - Morphine Sulfate Solution 100 mg per 5 ml (100/5 ml), to take 0.25 ml by mouth every 4 hours as needed, dated 4/45/24. - Morphine 20 mg/ml oral concentrate, take 0.25 ml by mouth daily at bedtime for terminal restlessness/anxiety, dated 5/1/24. - Morphine 20 mg/ml, to give 0.25 ml by mouth every 2 hours and every 2 hours as needed, dated 5/2/24. Resident B's Medication Administration record from 4/25/24 to 5/2/24 indicated the resident was administered morphine on the following dates and times: 4/25/24 at 9:43 P.M. 5/1/24 at 8:00 P.M. 5/1/24 at 12:09 A.M.	R 0243	Nursing staff will document all medication administration in the medical record, including time of administration, reason for administration, and the follow up regarding the effectiveness of the medication administration. Nursing staff will administer only medications they have prepared per policy. All residents had the potential to be affected by this deficient practice. An audit scheduled on 5/29/24 of resident medication administration records to verify all medications are being documented as ordered. All medication passers in-service on 5/17/24 of medication administration documentation expectation and policy, including QMA scope of practice. Clinical staff will pass medications per policy, immediately. The DON/designee and ED/designee will review the medication administration record weekly to ensure medication administration documentation is completed per policy. All medication passers were re-educated on medication administration processes on 5/17/24. All medication passers will complete medication administration competency check off by 6/14/24. Monthly medication administration in-services will be conducted to review policies and	06/14/2024

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	5/2/24 at 8:00 A.M. 5/2/24 at 12:00 P.M. Resident B's Progress Notes, indicated morphine was administered on 5/2/24 at 12:00 P.M. per Hospice instructions. Resident B's "CONTROLLED DRUG REPORT RECORD/DISPOSITION FORM," dated from 4/24/24 to 5/2/24, indicated morphine was administered on the follow dates and times: 4/24/24 at 3:22 (does not document A.M. or P.M.) 4/24/24 at 9:30 (does not document A.M. or P.M.) 4/24/24 at 10:57 A.M. 4/25/24 at 9:30 P.M. 4/27/24 at 9:30 P.M. 4/28/24 at 9:30 P.M. 5/1/24 at 12:00 A.M. 5/1/24 at 9:00 P.M. 5/2/24 at 8:00 A.M. 5/2/24 at 12:00 P.M. 5/2/24 at 2:35 P.M. 5/2/24 at 3:40 P.M. 5/2/24 at 5:20 P.M. During an interview with the Interim Director of Nursing on 5/14/24 at 11:21 A.M., she indicated nursing staff did not consistently document in the Electronic Medication Administration Record (EMR) when morphine was administered to Resident B. Medication administrations should be documented in the MAR including the time of administration, reason for the administration, and the follow up regarding the effectiveness of the medication administration. During an interview with Employee 2 on 5/14/24 at 1:15 P.M., he indicated on 5/1/24, Employee 4 had prepared Resident B's morphine dosage and instructed him to administer the medication at 9:00		procedures of medication administration and expectations. New hires will complete medication administration competency check off with DON/designee and complete training for acceptable mediation administration practices before passing any medications at this community. The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing EMAR report administration records weekly at ROAR meeting for 4 weeks, then monthly for 3 months to ensure PRN medications that are administered by QMA include required documentation in the medical record, to including time of administration, reason for administration, and the follow up regarding the effectiveness of the medication administration. The audit willbe discussed monthly with regional 1:1 meeting. The Regional Director will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	

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	P.M. He indicated Employee 4 told him she had attempted to administer the morphine to the resident at 8:00 P.M., and the resident refused it because she wanted to take it (the morphine) at 9:00 P.M. Employee 2 indicated Employee 4 did not stay until 9:00 P.M. to administer the medication. Employee 2 confirmed he had administered the morphine dose at 9:00 P.M. and signed the MAR even though he did not prepare the medication. Employee 2 indicated nursing staff were not to pass medications they had not prepared themselves. During an interview with the Interim Director of Nursing on 5/15/24 at 9:55 A.M., she indicated Employee 4 had stayed past her shift on 5/1/24 to help with the evening medication pass and had prepared Resident B's medications . Employee 4 prepared a dosage of morphine for Resident B and directed Employee 2 to administer the medication. The Interim Director of Nursing indicated under no circumstances should a nurse ever pass medications prepared by another nurse. On 5/14/24 at 10:53 A.M., a policy titled, "Medication Administration Policy & Procedures," dated 2/24/22, was provided by the Interim Director of Nursing, who indicated it was the current facility policy. The policy indicated, "...The community will ensure that Residents are given their correct medication at the right time, in the right dosage per their physician's orders, and per state regulations...A separate medication record (eMAR/MAR) shall be maintained for each resident receiving medication administration and shall include:...Date and time of actual medication administration, signature or initials of the employee administering medication, For PRN medication, record the date, time ,.. on the eMAR..."			

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R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by 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 record review and interview, the facility failed to ensure PRN (as needed) medications administered by a QMA (Qualified Medication Aide) were signed off by a licensed nurse for 1 of 3 residents reviewed for PRN medication administration. (Resident B). Finding includes: On 5/13/24 at 1:37 P.M., the clinical record for Resident B was reviewed. Diagnoses included hypertension and arthritis. Resident B was under Hospice Care and the most recent Hospice Physician Certification of Terminal Illness document dated 4/18/24, indicated diagnoses included heart failure, heart block, and shortness of breath and the resident required assistance with activities of daily living including dressing, grooming, toileting, and bathing. Physician's Orders included the following: - Morphine Sulfate Solution 100 mg per 5 ml (100/5 ml), to take 0.25 ml by mouth every 4 hours as needed, dated 4/45/24.	R 0246	The facility will ensure PRN (as needed) medications administered by QMA (Qualified Medication Aide) are reviewed, approved, and delegated by a by a licensed nurse before administration. All residents had the potential to be affected by this deficient practice. A chart audit scheduled on 5/30/24 to verify that PRN medications administered by a QMA have been reviewed, approved, and delegated by a licensed nurse before administration. Any PRN's found to have missing approvals were flagged for the DON to review for staff noncompliance and what further education and disciplinary counseling up to an including termination is warranted. The DON/designee and ED/designee will review the medication administration record	06/14/2024

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	- Morphine 20 mg/ml oral concentrate, take 0.25 ml by mouth daily at bedtime for terminal restlessness/anxiety, dated 5/1/24. - Morphine 20 mg/ml, to give 0.25 ml by mouth every 2 hours and every 2 hours as needed, dated 5/2/24. Resident B's Medication Administration records from 4/25/24 to 5/2/24, indicated the resident was administered morphine on the following dates and times by QMAs, and lacked documentation of any notification to a Licensed nurse and authorization to administer the PRN medication: 5/1/24 at 8:00 P.M., administered by QMA 2 5/1/24 at 12:09 A.M., administered by QMA 9 5/2/24 at 8:00 A.M., administered by QMA 6 5/2/24 at 12:00 P.M., administered by QMA 6 During an interview with the Interim Director of Nursing on 5/14/24 at 11:21 A.M., she indicated QMA's were required to notify a licensed nurse to obtain permission before administering a PRN medication and were to document the contact. If they gave authorization to a QMA, licensed nurses were also supposed to document the notification and authorization in the resident's chart. During an interview with Employee 2 on 5/14/24 at 1:15 P.M., he indicated QMA's were required to call a Licensed nurse before giving a PRN medication. He indicated he did not always document the notifications. On 5/15/24 at 10:40 A.M., an undated document titled, "Qualified Medication Aide, Scope of Practice," was provided by the Administrator who indicated it was the current facility QMA scope of practice summary. The Scope of Practice indicated, "...Administer previously ordered pro re		routinely to ensure medication administration documentation is completed per policy. All medication passers were re-educated on medication administration processes on 5/17/24. All medication passers will complete medication administration competency check off by 6/14/24. The Regional Director of Nursing added a prompt in our EMAR system to read, “what nurse approved PRN”, requiring any QMA to document the approval by a licensed nurse before administering a PRN. Monthly medication administration in-services will be conducted to review policies and procedures of medication administration and expectations. New hires will complete medication administration competency check off with DON/designee and complete training for acceptable mediation administration practices before passing any medications at this community. The Executive Director is responsible for sustained compliance. The ED/designee will complete audits by reviewing EMAR report administration records weekly at ROAR meeting for 4 weeks, then monthly for 3 months to ensure PRN medications that are administered by QMA are reviewed, approved, and delegated by a licensed nurse prior to administration. The audit	

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		A. BUILDING 00 B. WING	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF EDISON LAKES	1025 PARK PLACE MISHAWAKA, IN 46545

(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
	nata (PRN) medication only if authorization is obtained from the facility's licensed nurse on duty or call. If authorization is obtained, the QMA must do the following: ... Document in the resident record that the facility's licensed nurse was contacted, symptoms were described, and permission was granted to administer the medication, including the time of contact...Ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty..." This citation relates to Complaint IN00434184		willbe discussed monthly with regional 1:1 meeting. The Regional Director will determine if continued auditing is necessary based on 3 consecutive months of compliance. Monitoring will be on-going.	