STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155786	A. BUILDING 00 B. WING	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

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F 0000 Bldg. 00		F 0000		

This visit was for the Investigation of Complaints IN00446808, IN00449114, IN00449466, and IN00449972.

Complaint IN00446808 - Federal/state deficiencies related to the allegations are cited at F0740 and F0921.

Complaint IN00449114 - No deficiencies related to the allegations are cited.

Complaint IN00449466 - Federal/state deficiencies related to the allegations are cited at F0580 and F0689.

Complaint IN00449972 - Federal/state deficiencies related to the allegations are cited at F0760.

Survey dates: January 2 and 3, 2025

Facility number: 012466
Provider number: 155786
AIM number: 201014060

Census Bed Type:
SNF/NF: 114
SNF: 17
Total: 131

Census Payor Type:
Medicare: 10
Medicaid: 77
Other: 44
Total: 131

These deficiencies reflect State Findings cited in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	accordance with 410 IAC 16.2-3.1. Quality review completed on January 10, 2025.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on interview and record review, the facility failed to timely notify a resident representative of a fall for 1 of 3 residents reviewed for falls. (Resident B) Findings include: The clinical record for Resident B was reviewed on 1/2/25 at 2:10 p.m. The diagnoses included, but were not limited to, Alzheimer's disease and hypertension. A Quarterly Minimum Data Set (MDS) assessment, completed 11/27/24, indicated she had severely impaired cognition, was able to transfer from a sitting to standing position, and walk with supervision and/or touch assistance of staff. She did not use a wheelchair and received scheduled pain medications. A care plan, last reviewed 12/19/24, indicated Resident B was at risk for falls due to a history of falls, impaired cognition, and utilization of certain medications. The goal was to reduce her risk factors to attempt to avoid significant fall related injuries. The approaches included, but were not limited to, keep personal items in reach, non-skid footwear, and environmental changes. A nursing progress note, dated 12/11/24 at 8:57 p.m. [recorded as a late entry on 12/13/24 at 1:06 a.m.], indicated Resident B was found in another	F 0580	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 the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident B no longer lives 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. • Whole house audit completed to ensure notification of family for residents who had falls 90 days prior to 01/03/2025. • All nursing staff educated on the Fall Management Policy. What measures will be put into	01/23/2025

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	resident's room, lying on the floor on her left side. Resident B was assessed, and no injuries were noted at that time. Her vital signs were stable. A nursing progress note, dated 12/12/24 at 11:46 a.m., indicated Resident B was noted to have pain in her left lower extremity. An as needed dose of Tylenol was administered. The Nurse Practitioner assessed Resident B, and a new order was received for Tylenol 650 milligrams (mg) four times daily for three days. A nursing progress note, dated 12/12/24 at 1:54 p.m., indicated the physician had ordered a STAT (right away) X-Ray of Resident B's pelvis due to acute pain. The X-Ray provider had been notified. A nursing progress note, dated 12/12/24 at 8:01 p.m., indicated a positive X-Ray had been received, the on-call provider was notified, and Resident B had been sent to an acute care hospital for treatment. Resident B was admitted to the acute care hospital on 12/12/24 for a left femoral neck fracture (hip fracture). During an interview on 1/2/25 at 3:02 p.m., Family Member (FM) 10 indicated she had not been made aware of Resident B's fall, on 12/11/24, until when she came to visit Resident B on 12/12/24. She had found Resident B sitting in a wheelchair, which was not normal for Resident B. Resident B was rocking back and forth, rubbing her leg and crying. The physician ordered an X-Ray, which showed Resident B had a fractured hip. On 1/3/25 at 8:56 a.m., the Executive Director (ED) provided a copy of the Incident Report submitted to the Indiana Department of Health (IDOH), on		place or what systemic changes you will make to ensure that the deficient practice does not recur? • All nursing staff were educated on the Fall Management Policy. • The licensed nurse will notify the family/responsible party and document notification of falls per fall management policy. • The DNS or designee will audit falls daily to ensure resident representatives have been notified timely. 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? • Resident Representative notification of Fall QA Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. • If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	12/12/24, and the investigation file. The investigation file included a statement, dated 12/13/24, from Registered Nurse (RN) 6 which indicated she had been the nurse caring for Resident B on 12/11/24. Resident B had been found on the floor and RN 6 had assessed Resident B and started neurological checks. Resident B did not display signs or symptoms of pain after being found on the floor. Resident B had walked to the dining room after being assisted from the floor. RN 6 had not documented the fall in the clinical record on 12/11/24. A statement from Certified Nurse Aide (CNA) 8 was included in the investigation file. The statement indicated CNA 8 had cared for Resident B during the night shift on 12/11/24. CNA 8 had provided care multiple times throughout the night. Resident B had not shown signs or symptoms of discomfort and was able to turn in bed with ease. A statement from Physical Therapist (PT) 7, dated 12/16/24, indicated PT 7 provided treatment for Resident B on 12/12/24 prior to lunchtime. PT 7 had been informed by the nurse caring for Resident B that Resident B had difficulty getting up that morning. PT 7 attempted to have Resident B do a sit to stand transfer using the handrail in the hallway. Resident B was able to stand with minimal assistance and had started to take steps using the handrail. PT 7 had asked Resident B about pain and Resident B nodded her head to indicate "yes" and indicated the pain was in her left thigh. The nurse had given Resident B pain medications and PT 7 escorted Resident B to the dining room using a wheelchair. A statement from RN 9, dated 12/18/24, indicated RN 9 had not been made aware that Resident B			

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	fell, on 12/11/24, during report from the night shift nurse. RN 9 had been informed that Resident B did not want to get up and walk to breakfast on 12/12/24. RN 9 had observed Resident B in the dining room during breakfast and had not noted any signs or symptoms of pain. Therapy had treated Resident B after breakfast and made RN 9 aware of Resident B having pain in her left leg. An Activities Assistant had informed RN 9 of Resident B's fall on 12/12/24. RN 9 had informed the Nurse Practitioner of the fall on 12/12/24 and received new pain medication orders. The physician was informed of the fall and ordered a STAT X-Ray of the pelvis. FM 10 had come to visit and was made aware of the fall and the new orders received. The X-Ray results were positive for a left hip fracture and Resident B was sent to an acute care hospital for treatment. During an interview on 1/3/25 at 11:24 a.m., the ED and the Director of Nursing Services indicated that FM 10 should have been made aware of Resident B's fall when it happened on 12/11/24. This citation is related to Complaint IN00449466. 3.1-5(a)(1) 3.1-5(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure care planned fall interventions were implemented for 1 of 3 residents reviewed for falls. (Resident F) Findings include:	F 0689	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 the 2567 Plan of Correction	01/23/2025

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	The clinical record for Resident F was reviewed on 01/02/25 at 11:50 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, fibromyalgia, and osteoarthritis. A physician order, dated 07/15/24, indicated to encourage use of hipsters at all times and nursing to check for use every shift. A care plan, dated 01/02/25, indicated Resident F was at risk for falls. The goal was for Resident F's fall risk factors to be reduced in an attempt to avoid significant fall related injury. The interventions included, but were not limited to, hipsters as recommended, fall mat to open side of bed, offer early get up, nonskid footwear, initiated on 05/12/23. On 01/02/25 at 11:42 a.m., Resident F was observed sitting up in a wheelchair at the nurse's station with no hipsters visibly noted. On 01/02/25 at 1:57 p.m., Resident F was observed sitting up in wheelchair at the nurse's station with no hipsters visibly noted. On 01/03/25 at 11:27 a.m., Resident F was observed with Licensed Practical Nurse (LPN) 3. LPN 3 was asked if Resident F had hipsters on, LPN 3 indicated she was unsure if Resident F was wearing hipsters. Upon observation, LPN 3 indicated Resident F did not have her hipsters on. Resident F's room did not contain hipsters. LPN 3 was asked if she was aware that Resident F should be wearing hipsters, LPN 3 indicated she was unsure and she knew Resident F had been wearing them in the past but did not know what happened to them. On 01/03/25 at 8:56 a.m., the ED provided the Fall		be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Hipsters were immediately placed on Resident F **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 that have fall interventions have the potential to be affected by the alleged deficient practice All residents were audited to ensure appropriate fall interventions are present per care plan. All nursing staff will be in-serviced on fall interventions by _____. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All nursing staff and IDT team will be in-serviced on fall plan of care and interventions. The DNS/designee(s)/IDT team will round daily each shift to ensure fall interventions are in place.	

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	Management Policy, last revised March 2024, which read "...Communities will implement resident-centered fall prevention plans for each resident at risk for falls or with a history of falls within the past 6 months...The family or responsible party will be notifies immediately by the charge nurse of falls with injury...If there are no injuries, notify the family by the end of the shift..." This citation is related to Complaint IN00449466. 3.1-45(a)(1) 3.1-45(a)(2)		**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?** Fall interventions QA Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	
F 0740 SS=D Bldg. 00	483.40 Behavioral Health Services Based on interview and record review, the facility failed to document a resident's behaviors, implement behavior interventions that were put in place to address the resident's behaviors, and evaluate the effectiveness of behavior interventions for 1 of 3 residents reviewed for abuse. (Resident H) Findings include: The clinical record for Resident H was reviewed on 1/2/25 at 11:30 a.m. The diagnoses for Resident H included, but were not limited to, stroke affecting left side and dementia. The resident was admitted to the facility on 11/1/24. An Admission MDS (Minimum Data Set) assessment, dated 11/7/24, indicated the resident	F 0740	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 the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident H's behaviors were documented and care plan updated, interventions were	01/23/2025

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	was cognitively intact. A care plan, dated 11/4/24, indicated the resident required staff assistance with toileting and incontinent care. A nursing note, dated 11/17/24, indicated the following, "...Resident [H] has been riding through the halls disturbing other residents yelling. Stating he is in h--l, family members are asking, Is he OK? Writer tried to clam (sic) resident down while riding pass the nurses station. Although resident ignored writer and proceed to go down the front 500 hall." A care plan, dated 11/20/24, indicated the resident was "having episodes of cursing, yelling, screaming, becomes belligerent and physically aggressive towards staff." The interventions included, but were not limited to, the following: the staff was to provide care in pairs, encouragement to express feelings, administer medications as ordered, and provide mental health services. A behavior progress note, dated 11/30/24, indicated "Resident upset and refused all evening medications r/t [related to] he had to wait for extended period of time before the CNA [certified nurse aide] could provide care. Resident felt he shouldn't have to wait and he expressed that he doesn't care that other people need help as well. He should've been provided care for before others and stated that staff should stop what they are doing and tend to his needs. Interventions attempted: Writer tried to talk to resident and explain that everyone requires care and that we all have to be patient until staff is able to attend to each person. Resident didn't like that response and stated he didn't care. Effectiveness of		immediately implemented to address the resident's behaviors. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • Any residents that have had behaviors have the potential to be affected by the alleged deficient practice • All residents were audited to ensure appropriate behavioral care plans and interventions were documented and are in place. • All nursing staff will be in-serviced on documenting behaviors and all clinical staff will be educated on implementing behavior interventions and documentation of effectiveness of interventions. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • All nursing staff will be in-serviced on documenting behaviors and all clinical staff will be educated on implementing behavior interventions and documentation of effectiveness of interventions. • The ED/SSD/designee will review EMAR to ensure behavior interventions are being implemented, in place and effectiveness documented. • The ED/SSD/designee will audit new behaviors daily to ensure	

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	Interventions: resident yelled at writer and told writer to leave room. Writer provided space for resident to calm down." A care plan meeting summary, dated 12/11/24, indicated Resident H and his representative attended the care plan meeting. The resident "appeared agitated after a few minutes and left the meeting." The resident "returned to the meeting and then left abruptly again." The summary included documentation of discussion during the meeting. It indicated the following, "Writer discussed some of res [Resident H]'s behaviors with his [representative] (sexually inappropriate comments, yelling etc.) and her response was 'some of that can't you just laugh off' and other times during the conversation she apologized for his behavior." A care plan, dated 12/16/24, indicated Resident H has made inappropriate sexual comments to staff members. The interventions included, but were not limited to, the following: the staff was to provide care in pairs, provide mental health services, and reminders to the resident the sexual comments were inappropriate. A nursing note, dated 12/18/24, indicated "Resident is causing a scene in his room. Writer walked into room along with his [representative]. Present was CNA and resident's friend who was visiting. Staff was explaining the reason for not using the stand up lift. Writer tried to explain again that it is safety issue. Educated resident on what ED [Executive Director] had explained earlier about the different lifts. Resident starting yelling [sic] and becoming belligerent towards staff and visitors. [Representative] was trying to calm resident down and resident started in on yelling at his [representative]. Resident stated can we give		clinical documentation is recorded. 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? • Behavior Management QA Tool will be utilized weekly x 4 weeks, monthly x 6 months, and quarterly thereafter with results reported to the Quality Assurance and Performance Improvement Committee overseen by the Executive Director. • If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance.	

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	him a lethal injection of something to take him out cause he doesn't want to be here. Resident's yelling and screaming so loud that it's scaring the other resident's on the hall and other family members who are here visiting loved one's [sic]. Resident has his [representative] in tears at this time and told writer and CNA to get out of his face and get out of his room and don't come back in there. Staff left resident's room immediately..." A care plan, dated 12/19/24, indicated Resident H having difficulty adjusting to living in long term care. Resident H makes statements; "What can I do to get myself kicked out of here? My wife just dumped me off." An event report, dated 12/19/24, indicated the staff was to monitor Resident H's behaviors related to sexual statements, screaming, yelling/raising his voice, and aggression toward staff and/or residents. The evaluation notation indicated "continues to exhibit these behaviors at times." A care plan, dated 12/30/24, indicated the resident has "made false allegation towards staff." The interventions included the following: the staff was to provide care in pairs, resident concerns were to be investigated and provide mental health services to the resident. Resident H's clinical record did not have documented behavior events and/or incidents the resident had episodes of behaviors related to inappropriate sexual comments. The resident's individualized behavior care plan interventions put in place were not implemented or evaluated to ensure effectiveness. A reportable incident, dated 12/24/24, indicated			

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	"...Resident (H) stated that [CNA 4] made negative statements to him...Follow up...Investigation including resident/staff interviews completed with no care concerns identified. Resident has not voiced any concerns during investigation an showed no s/s [signs and symptoms] psychosocial distress." The investigation of the reportable incident was provided by the ED on 1/3/25 at 8:56 a.m. It included the following: A statement by the ED, not dated, indicated "At approximately 11 a.m. [11:00 a.m.] on 12/24/24, [ED] asked [Resident H] how his night went. [Resident H] stated that it did not go well. [ED] asked for clarification as to what [Resident H] meant. [Resident H] said that the girl in the middle of the night told me 'she was one of two people that could give me a lethal injection.' [ED] asked [Resident H] if he knew her name. [Resident H] stated that he did not but described her as short and stout. [ED] asked if [Resident H] was feeling fearful of her, he stated 'not really but wanted you to know'." A statement by CNA 4, dated 12/24/24, indicated "...I, [CNA 4] was providing care to [Resident H] on 12/23/24. As I was giving care, [Resident H] stated 'Do you have a cork' I replied 'What?' He responds and says 'A butt plug' and I replied '[Resident H] stop talking to me that way.' then he proceeds to say 'Are you going to give me a lethal injection.' I ignored him and finished cleaning him up. [Resident H] frequently says inappropriate remarks to staff and the nurses are aware..." A statement by License Practical Nurse (LPN) 15, not dated, indicated "On the morning of 12/24/24, I had not noticed [Resident H]'s light being on			

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	any more than usual. He had his call light on and I answered it. He said he needed to be changed and I told him I would get a CNA. He told me not bring [name of a female] back. I explained there is no one working by that name. He said 'she'll use lethal force on me.' I got a CNA from the other hall as his CNA was on break. The CNA provided care. I told the night supervisor that he did not want to work with the CNA name [name of a female]." A statement by CNA 14, not dated, indicated "I provided care to [Resident H] early morning of 12/24/24 while his aide was on break. [Resident H] did not seem to be in a bad mood. Care was provided without an incident or negative statements." An interview was conducted with Resident H on 1/3/25 at 10:00 a.m. He indicated he did not have any concerns with staff treatment. He denied being abused. An interview was conducted with CNA 14 on 1/3/25 at 11:11 a.m. She indicated she did provide care for Resident H on 12/24/24. She was providing care due to his CNA that was assigned to him was on break. CNA 14 has provided care to Resident H a few times. She did not have any other staff member present on 12/24/24, while providing care to him. The nurse had walked into the room, but she had already completed the care. CNA 14 was told this week that Resident H's care for now on was to be completed with two staff members. Prior to this week, she had provided care to the resident alone. An interview was conducted with ED on 1/3/25 at 2:10 p.m. He indicated Resident H was first admitted in November as a respite stay. The			

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	resident's representative had changed her mind and decided the resident would remain in the facility permanently. Resident H was upset when he was made aware he would be staying long term. ED was made aware during a morning meeting; the resident was making inappropriate sexual comments to the staff. At that time, it was discussed during a care plan meeting (12/11/24) with his representative and care planned. The staff should have been documenting the behaviors in the resident's medical chart. The resident at times does make statements in a joking manner to the staff about receiving lethal injections from them. A Behavior Management policy was provided by the ED on 1/3/25 at 8:56 a.m. It indicated the following, "...Policy: It is the policy of [name of corporation] to provide behavior interventions for residents with problematic or distressing behaviors. Interventions provided are both individualized and non pharmacological and part of a supportive physical and psychosocial environment that is directed toward preventing, relieving and/or accommodating a resident's behavioral expressions. Procedure: 1. Care plans should be initiated for any behavioral expression that is problematic or distressing to the resident, other residents or caregivers. Care plan interventions should include individualized and nonpharmacological interventions which address both proactive and responsive interventions...3. When a behavioral expression occurs, the staff communicates to the nurse what behavior occurred. The nurse records the behavior in Matrix. 4. If the behavioral expression is new, worsening, or high risk, the nurse will record the behavior using the New/Worsening Behavior Event. New or worsening behaviors are reviewed by the IDT [interdisciplinary team] for assessment			

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	and preventative actions. New/Worsening Behaviors include...d. Behaviors that have potential for risk to others including sexual advances...combativeness with care..." This citation is related to Complaint IN00446808. 3.1-37(a)			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to administer a synthetic opioid pain patch in accordance with the physician order, the manufacturer's specifications, or accepted professional standards to prevent a significant medication error for 1 of 3 residents reviewed for medication regimen. (Resident C) This deficient practice resulted in the resident having two opioid pain patches applied simultaneously, the resident experienced a significant change in consciousness that required emergent administration of an opioid overdose medication, and hospitalization. This deficient practice was corrected on 12/31/24, prior to the start of the survey, and was therefore past noncompliance. The facility implemented a systemic plan that included the following actions: in-service education to nursing staff related to the policy and procedure regarding synthetic opioid pain patches, conducted competency check offs for medication administration for nursing staff, and conducted a review of residents who received a synthetic opioid pain patch with ongoing review presented to the Quality Assessment and Assurance (QAA) Committee for review.	F 0760	What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? • All licensed nurses were educated on administration/policy of synthetic opioid pain patches by 1/4/25 . • Resident C no longer has an order for synthetic opioid pain patch. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?¿ • No residents in the facility currently have an order for synthetic opioid pain patch. • All licensed nurses were educated on administration/policy of synthetic opioid pain patches by 1/4/25. What measures will be put into	01/20/2025

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	Findings include: The clinical record for Resident C was reviewed on 1/2/25 at 11:00 a.m. The diagnoses for Resident C included, but were not limited to, quadriplegia. A Quarterly MDS (Minimum Data Set) assessment, dated 11/6/24, indicated the resident was cognitively impaired. Resident C was receiving pain management. A physician order, dated 6/8/24, indicated the resident was to receive four milligrams of Narcan [medication that can reverse opioid overdose] in nostril for drug sedation as needed. A physician order, dated 7/17/24, indicated the resident was to receive 15 milligrams (mg) of morphine twice a day as needed for pain. A physician order, dated 7/17/24, indicated the resident was to receive one 75 micrograms (mcg) fentanyl (synthetic opioid medication) patch every three days for pain. The order was discontinued on 12/27/24. The November 2024 Medication Administration Record (MAR) indicated the 75 mcg fentanyl patch was administered with the location of the patch on the following days: 11/23/24 placed on the right chest, 11/28/24 placed on the right upper back, and 11/30/24 placed on the chest. The MAR did not include documentation of the removal of the fentanyl patches. A November 2024 controlled substance administration record indicated nursing staff placed a fentanyl 75 mcg patch on Resident C five times in eight days on 11/23/24, 11/24/24, 11/27/24,		place or what systemic changes will you make to ensure that deficient practice does not recur? • DNS/Designee to check opioid pain patch administration daily to ensure compliance with policy. There are no residents in the facility currently with an order for synthetic opioid pain patch. 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? • Fentanyl QA tool to be completed weekly x 4, monthly x 6 then quarterly thereafter until compliance is maintained. • The Regional Clinical Consultant/Designee will provide ongoing training, oversight, resources, and competencies as needed upon identifying on-going areas of concern or areas not meeting threshold. If a threshold of 95% is not achieved, an action plan will be developed to ensure compliance. The facility will review, update, and make changes to the POC as needed with input and oversight from the Regional Clinical Consultant for sustaining substantial compliance for no less than 6 months. After six months	

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	11/28/24, and 11/30/24. The record did not include documentation of the removal of the fentanyl patches. Resident C's clinical record did not include documentation to indicate the resident was monitored for a change of condition after receiving the pain patch five times within the eight-day period. A medication error report, dated 12/26/24, indicated Qualified Medication Aide (QMA) 10 administered the fentanyl patch to Resident C on 11/24/24 in error. The patch was supposed to be administered on 11/26/24. After, QMA 10 administered a fentanyl patch, on 11/28/24, in error. The patch was supposed to be administered on 11/30/24. The resident's previous fentanyl patches were not removed prior to administration of the new fentanyl patches on 11/24/24 and 11/28/24. The report indicated the measures taken for prevention of reoccurrence was demotion of QMA 10 to a Certified Nurse Aide (CNA). The December 2024 MAR indicated Resident C received a fentanyl 75 mcg patch on the following days and location of the patch: 12/21/24 placed on the chest and, on 12/24/24, placed on right side of the chest. The MAR did not include documentation of the removal of the fentanyl patches. On 12/24/24 at 9:13 p.m., Resident C received 15 mg of morphine as needed with a pain level of eight for generalized pain. A December 2024 controlled substance administration record for Resident C indicated nursing staff placed a fentanyl 75 mcg patch on 12/21/24 at 8:00 p.m. and 12/24/24 at 8:00 p.m. A nursing progress note, dated 12/25/24 at 4:32		the QAPI committee will re-evaluate the continued need for the audit.	

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	a.m. indicated, "this writer was providing care for resident roommate when she [Resident C] was observed to be gargling and foaming at the mouth, resident was extremely difficult to arouse and was incoherent with responding to verbal commands, resident eyes closes, skin cool clammy and ashen in color, 2 [two] fentanyl patches were in place on right and left side of resident chest, one dated 12/21 and one dated 12/24, old patch was removed, and nasal narcan spray administered at 4:07 a.m. x 1 [times one] dose, resident started to become more coherent within 5 [five] min [minutes] were resident vitals WNL [within normal limits], [blood pressure] 150/68, P [pulse] 79 RR [respiration rate] 16 post Narcan, resident agitated and in pain, 911 called and resident to be sent to [name of hospital] for further evaluation , voicemail left for emergency contact, DNS [Director of Nursing Services] and MD [medical doctor] notified of change in condition..." A reportable incident to the Indiana Department of Health, dated 12/26/24, indicated a medication error had occurred on 12/25/24 at 4:01 a.m. Resident C was sent to the hospital for evaluation. The investigation for the medication error was provided by the Executive Director on 1/3/25 at 8:56 a.m. It included, but was not limited to, the following: A written statement by Licensed Practical Nurse (LPN) 11, dated 12/26/24, indicated "on 12/24/24 upon administering prescribed medication [75 mcg fentanyl patch] to resident [C]. Resident's roommate started yelling saying that she was in pain in her chest. I stopped to check the roommate and forgot to take off other patch amongst the chaos in the room."			

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	A medication error report, dated 12/25/24, indicated "fentanyl patch was not removed when applying new patch." The medication error resulted in "resident needed to be narcan [sic] & sent to hospital." The report indicated the measures taken for prevention of reoccurrence was presence of two nurses with the removal and application of fentanyl patches. An in-service was conducted with staff, on 12/26/24, for medication errors. The hospital records, dated 12/25/24 through 12/27/24, indicated the following, "...found pt [patient] unresponsive and realized pt was wearing 2 [two] fentanyl patches. Pt still wearing one fentanyl patch on arrival, removed by...ED [emergency department] staff...RNs [Registered Nurses] at [name of facility] admin [administered] intranasal narcan. Pt vitally stable on arrival...Patient seen and examined. Patient was brought into the ED as she was found to be unresponsive at ECF [extended care facility] though the patient has no recollection that she was at the ECF. Patient was confused at the time of admission thinking that she had come from home. Patient was noted to have 2 [two] fentanyl patches on at the ECF and they were removed and patient was given a dose of Narcan...and she became much more responsive...1. Increased somnolence-secondary to narcotic patch...Appears to be at baseline mentation at this time...5. Chronic pain - patient was found to have 2 fentanyl patches on at the time of admission. Received narcan prior to admission. Continue morphine and Lyrica. Will resume fentanyl patch tomorrow...Principal Problem: toxic metabolic encephalopathy suspected to be secondary to narcotic overdose. Mentation now appears to be			

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	at baseline. Seen by neurology who has cleared her for discharge..." Resident C was discharged on 12/27/24. An interview was conducted with Resident C on 1/3/25 at 11:38 a.m. She indicated she could not recall the incident. She no longer received fentanyl patches. An interview was conducted with the Director of Nursing Services (DNS) and Float Director of Nursing Services (FDNS) on 1/3/25 at 2:49 p.m. They indicated a medication error had occurred on 12/24/24. Nursing staff had placed a 75 mcg fentanyl patch on Resident C, as ordered, but had not removed the previous one. Resident C had two fentanyl patches on. FDNS indicated emergency medical services (EMS) was notified and administration of Narcan was initiated. Resident C was sent to the hospital for evaluation. The resident remained in the hospital for a couple of days, but it was not due to wearing two fentanyl patches. During her hospital stay, blood levels for fentanyl were not even obtained. On 11/24/24 and 11/28/24, medication errors had also occurred with the resident's fentanyl patches. The nursing staff had administered the fentanyl patches to Resident C prior to the 72 hours as ordered. The staff did not remove the previous fentanyl patches prior to administering the new fentanyl patches, so the resident was also on those days wearing two patches. After hospitalization, Resident C's fentanyl patch order was discontinued. An email statement by Physician 13, dated 1/3/25, was provided by the FDNS at 1/3/25 at 2:54 p.m. It indicated the following, "...I have reviewed the chart and this is my thought on this. After removing the patch for 24 hours, the			

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	concentration of fentanyl in the serum gradually decreased to about 50% after 17 hours (range:13-22 hours). These results indicated that the fentanyl continued to be released into the blood from the skin after drug withdrawal. But this also indicates that if a patch was still in place after the 72 hour mark the concentrations were likely decreasing at rapid rates. Meaning that I don't think that the fentanyl patch that was older was likely contributing much to the newer patch that was in place. It doesn't mean that the patches should not be removed, removing a patch at the 72 hour mark increases the rate of fentanyl blood concentration more rapidly allowing the second patch to have less total blood concentration at the 24-hour mark from when it is first put in place. That being said it likely was not contributing significantly. Despite the MRI [tube like machine to see images of organs and tissues in body] a being negative it is curious that the CTA [computed tomography angiography - diagnostic imaging procedure that uses X-ray technology and computer processing to create detailed images of blood vessels and surrounding tissues] indicated a possible acute or subacute thrombus [clot]. Partial occlusion may have attributed for part of her symptoms. Simply saying that someone gets narcan and wakes up is not enough to indicate that it was entirely the opiates fault. Especially in a fentanyl patch, it remains in the blood for 17 hours as stated above. Which would mean one or two doses of narcan would only last an hour and a half and she would still have over 50% of the original concentration in her blood despite taking both patches off immediately upon arrival. That would mean that narcan would need to be continually infused over the next 17 hours to remain effective. I think this is a deficiency that the hospital team is overlooking in blaming the fentanyl entirely...."			

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	A medication administration procedure policy was provided by the Executive Director on 1/3/25 at 8:56 a.m. It indicated the following, "...3. Medications to verify order with label...10. Perform the 5 [five] rights of medication: Right Resident, Right Medication, Right Dose, Right Route, Right Time...19. Medication administration will be recorded on the MAR/EMAR... after given...." The website Drugs.com at https://www.drugs.com/cdi/fentanyl-transdermal-patch.html , retrieved on 1/7/25 at 5:00 p.m., updated December 21, 2023, indicated the following, " ...Fentanyl Transdermal Patch ...How is this medicine (Fentanyl Transdermal Patch) best taken?... Take off old patch first ... Put patch on clean, dry, healthy skin on the chest, back, upper leg, or upper arm ... Put the patch in a new area each time you change the patch ... What do I do if I miss a dose? ...Do not apply double dose or extra patches ...." The website National Library of Medicine at https://www.ncbi.nlm.nih.gov/books/NBK470415/ , retrieved on 1/7/25 at 5:05 p.m., updated July 21, 2023, indicated the following, " ...Formulas of Opiates and Delivery ... The transdermal delivery of opiates like fentanyl has been widely accepted in healthcare settings for analgesic relief. This route of administration is favored because the drug levels take 4 to 6 hours to peak and there is a long elimination half-life, thus making the drug suitable for use in patients with chronic continuous pain ... However, the topical formulation of fentanyl can contribute toward the toxicity of parenteral or oral opiates ... Evaluation ... Laboratory Studies ... Patients with drug overdose usually undergo several investigations. Drug screens are readily available but often do			

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	not change the initial management of straightforward cases ... In patients with opiate toxicity or overdose, the following blood work is usually performed: Complete blood cell count ... Comprehensive metabolic panel ... Creatine kinase [CK] level [Elevated CK levels may indicate muscle, heart, or brain damage or degeneration] ... Arterial blood gas determinations ... Starting Dose of Naloxone ... In patients who have taken large doses of ... fentanyl, much larger doses of naloxone are usually required to reverse the toxicity ... If the patient fails to respond to a total of 10 mg of naloxone, the diagnosis of opiate toxicity should be reconsidered ...." This citation is related to Complaint IN00449972. 3.1-48(c)(2)			
F 0921 SS=D Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to ensure the environment was free from strong urine odors for 1 of 3 residents reviewed for environment (Resident J). Findings include: The clinical record for Resident J was reviewed on 01/02/25 at 2:15 p.m. The diagnoses included, but were not limited to, neuromuscular dysfunction of bladder and urinary retention. A care plan, initiated on 12/05/2018, indicated that Resident J required an indwelling urinary catheter related to the diagnoses of neuromuscular dysfunction of bladder, urinary retention, and was at risk for infection. The goal was that Resident J	F 0921	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 the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • Resident J's room was immediately cleaned and the	01/23/2025

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	would have catheter care managed appropriately as evidenced by not exhibiting signs of urinary tract infection or urethral trauma. The interventions included, but were not limited to, record urinary output every shift, medications as ordered, and keep catheter system a closed system as much as possible. On 1/2/25 at 11:33 a.m., the 500 hallway was observed to have a strong urine odor in the hallway. The urine odor was noted to be coming from Resident J's room. During an interview on 01/02/25 at 11:39 a.m., Resident J indicated her urinary catheter frequently leaked onto the floor. The catheter was changed a week ago. Resident J did not think the staff locked the tubing on the bag correctly resulting in the leakage. On 01/02/25 at 1:57 p.m., the 500 hallway was observed to have a strong urine odor. On 01/03/25 at 11:36 a.m., the 500 hallway was observed to have a strong urine odor, which originated at Resident J's room. During an interview on 01/03/25 at 3:07 p.m., Housekeeping Aide (HA) 2 indicated she mopped urine off the floor 2-3 times a week in Resident J's room due to urine leakage from the catheter bag. HA 2 was unsure if the nursing assistants were closing the catheter bag correctly. HA 2 indicated she notified the staff when it occurred. During an interview on 01/03/25 at 3:18 p.m., the Director of Nursing Services (DNS) and Executive Director (ED) indicated they were unaware of a strong urine odor in the 500 hallway and no concerns had been raised to them regarding		catheter bag was confirmed to be properly clipped. 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 with catheters have the potential to be affected by this alleged practice; however, no residents were affected by this deficiency as demonstrated by a full audit of residents with catheters ensured that all catheters were properly clipped, and rooms were order free. • All clinical staff will be educated on proper clipping of catheters bags on or before 01/10/2025. • All rooms with residents that have catheters will be deep cleaned on or before 01/10/2025 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • DNS or Designee will conduct an in-service with all nursing staff and IDT team on properly clipping catheters bags on or before 01/10/2025 • The DNS/Designee/IDT team will round daily to ensure catheter bags are clipped properly and the room is free of odors. 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?	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISONVILLE MEADOWS	10312 ALLISONVILLE RD FISHERS, IN 46038

(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
	nursing staff not clamping the urinary bag closed. This citation is related to Complaint IN00446808 3.1-19(f)(5)		• Environmental Supervisor will complete the Environmental QAPI tool weekly times four, then monthly times six , and quarterly times thereafter. If the threshold of 95% is not achieved, an action plan will be developed to ensure compliance and results will be reviewed in QAPI Committee monthly.	