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	08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
STORYPOINT FORT WAYNE WEST	611 W COUNTY LINE RD SOUTH FORT WAYNE, IN 46814

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414047 and IN00414448. Complaint IN00414047 - No deficiencies related to the allegations are cited. Complaint IN00414448 - State deficiencies related to the allegations are cited at R0243. Survey date: August 16, 2023 Facility number: 011804 Residential Census: 98 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed August 21, 2023	R 0000	The submission of the Plan of Correction does not indicate an admission by Storypoint Fort Wayne West that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of Storypoint Fort Wayne West. The Community hereby maintains it is in substantial compliance with the requirements of participation for residential health care communities. To this end, the Plan of Correction shall serve as the credible allegation of compliance with all State requirements governing the operations of this Community. Storypoint Fort Wayne West respectfully requests a desk review for paper compliance.	
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 administering the drug or treatment. Based on interview and record review the facility failed to ensure residents' medications were	R 0243	1. Resident “B” had a medication error discovered on	09/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Renee Kreienbrink	Administrator	08/31/2023

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	administered as ordered, documented accurately, and accurate identification of the resident was implemented to prevent medication errors for 3 of 3 residents reviewed. (Resident B, Resident C, and Resident D) Findings include: Review of the facility's state reportable incidents provided by the facility on 8/6/2023 at 10:48 A.M., indicated 3 medication error incidents were reported to the state agency. 1. A record review for Resident B began on 8/6/2023 at 11:00 AM, indicated diagnosis included, rheumatoid arthritis, atrial fibrillation, hypertension, peripheral vascular disease, major depression and mild cognitive impairment. Resident B's Service Plan dated 1/31/2023, signed by the POA (Power of Attorney) on 2/27/23, indicated resident required staff attention (reminders or administration) to take medications. The State reported incident indicated a medication error involving Resident B was discovered on 5/30/23 for the medication, methotrexate (used to suppress the body's immune response, treatment for Rheumatoid Arthritis), The methotrexate 2.5 mg (milligram, a dose measurement) was to be administered 1 time every 7 days. The incident report indicated the medication was administered daily. An order with a start date of 4/27/2023 for methotrexate 2.5 mg was to give 4 tablets to equal 10 mg by mouth (PO) every week on Saturdays. Also an order for leucovor CA (used to prevent harmful effects of methotrexate, also used to treat overdoses of methotrexate) 5 mg was to give 1		5/30/2023. Nurse Practitioner was immediately notified and instructed staff to call Poison control and to send the resident to the ER for evaluation and treatment. The family and Wellness Director/Executive Director were notified. Resident “B” was alert and oriented with no complaints of pain or discomfort but complained of feeling tired. The order was clarified by the Assistant Wellness Director. The Assistant Wellness Director immediately discontinued the orders and entered the new orders and specified the day of the week for the medications to be given. Resident “C” was administered another resident’s medication on 6/15/2023 in error. The Nurse Practitioner was notified, and an order was given to hold the Eliquis that day due to due to the actions of the aspirin that was given. The Psychiatric Nurse Practitioner was also notified, and no new orders were given. It should be noted that the resident’s updated picture was present in the Medication Administration Record. Resident “D” was administered medications that were previously administered by QMA #4. QMA #2 administered the medications again because the medication had not be documented on the Medication Administration Record as given. The Nurse Practitioner was notified and was in the	

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	tablet every week on Saturday 1 to 2 hours prior to the methotrexate. The May 2023 Medication Administration Record (MAR) indicated to give methotrexate 2.5 mg (10 mg) po once per week. The May 2023 MAR documentation indicated the methotrexate was administered on 5/23/2023, 5/24/2023, 5/26/2023, 5/27/2023, 5/28/2023, 5/29/2023. The May 2023 MAR also indicated to give leucovor CA 5 mg 1 tablet PO the day of methotrexate (1-2 hours before). The documentation on the May 2023 MAR indicated leucovor CA 5 mg was administered on 5/23/23, 5/24/2023, 5/25/2023, 5/26/2023, 5/27/2023, 5/28/2023, 5/29/2023 and 5/30/2023. The MAR indicated the medications were administered from 5/23/2023 to 5/29/2023. Review of Resident B's progress note dated 5/30/2023 at 10:45 A.M., indicated Resident B had an order for methotrexate 2.5 mg tablet, give 4 tablets (10 mg) by mouth on Saturday with leucovorin 5 mg 1-2 hours prior to giving the methotrexate. and also the leucovorin 5 mg 1 tablet on Sundays. The orders for the Pharmacy indicated to give methotrexate 4 tablets of the 2.5 mg po daily and leucovorin 5 mg, 1 tablet po daily. Due to data error the resident was given 10 tablets of the 2.5 mg tablets since 5/26/2023 and the leucovorin 5 mg 2-3 doses since 5/26/2023. Poison Control was notified and indicated to send the resident to ER (Emergency Room) for evaluation and treatment or possible admission. The Nurse Practitioner (NP) and a family member was notified. Resident B was alert and oriented, vital signs were within normal limits and Resident B only complained of tiredness. The progress note dated 6/1/2023 at 11:03 A.M., indicated the hospital was called and Resident B		Community at the time and assessed the resident. The family was notified as well as the Wellness Director/Executive Director. Resident “D” had no adverse reaction or side effects from the additional medication given. On 8/10/2023 the Nurse Practitioner indicated to hold Carvedilot 12.5 mg if systolic blood pressure was under 110. Resident “D” later found to be resting comfortably in bed. Resident denied pain or discomfort. There were no signs or symptoms or adverse reactions from the medication error. 2. The Community realizes that residents on Medication Administration have the potential to be affected. The systemic change is that all resident’s Medication Administration Records will be audited by use of the Medication Administration Record Audit Tool by the Wellness Director/designee. Any discrepancies will be immediately corrected with the corrective actions being documented. (Please see Exhibit “A”) 3. Licensed nurses and Qualified Medication Aides have been educated. The education regarded the following but was not limited to: -Medication error Standard Operating Procedures (Please see	

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	was admitted to the hospital and continued to receive the leucovor, they were doing very well and was projected to be discharged on 6/1/23. The progress noted dated 6/1/2023 at 1:30 P.M., indicated Resident B was readmitted to the facility, accompanied by a family member. Resident B was alert and oriented, walking steady with rolling walker, voiced no complaints of pain nor discomfort. Also reported leucovorin 15 mg was to be continued every 6 hours until 6/3/2023. During an interview on 8/16/2023 at 3:30 P.M., the DON indicated the medication error occurred when the facility had switched the electronic record companies. She indicated the medication orders and MAR were imported to the new system by the Pharmacy. The new system's MAR did not trigger a day of the week the methotrexate and leucovor was to be administered. They discovered, at day of the week was not imported to the new MAR. The Medication was assigned daily to be given by the nursing staff. She indicated the QMA (Qualified Medication Aide) can only view the assigned medications to be administered during their shift. The medications were assigned to be given on May 2023 MAR and indicated to be given weekly but no day of the week was assigned. The DON indicated she had not reviewed the medication card from the pharmacy to know if the day of the week was indicated on the medication card. She indicated a QMA had reported the possible medication error on 5/30/23 to the ADON (Assistant Director of Nursing) when the medications had "popped up" to be administered when it was not the usual day to be given. The medication error was reported to the NP, she ordered labs to be done and to call Poison Control. A family member was notified. Poison Control recommended to send the resident		Exhibit “B”) -Administration of outdated medication -Administration of the wrong medication -Administration of the wrong dose -Administration of medication by the wrong route -Administration of medication to the wrong resident -Administration of medication at the wrong time -Administration of medication without nurse delegation or not in accordance of nurse delegation -Administration of medication using the wrong technique or method -Failure to prepare, store, or administer a medication in accordance with the manufactures instructions -Failure to administer medications as ordered In addition, a power point presentation was also provided during the education regarding Medication Services and the Qualified Medicine Aide’s Scope of Practice. (Please see Exhibit “C”). 4. All medication errors will be reported to the Wellness Director at the time of the Medication Error Occurrence. Immediate notification to the Nurse Practitioner will be completed for recommendations, interventions, and any new orders. The	

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	to ER for evaluation and treatment. The DON indicated the resident returned to the facility sooner than they thought. When the May 2023 MAR was reviewed, it indicated the methotrexate and leucovor were administered, the medication was not "x" out on the days it was not to be given, and a specific day of the week was not listed. The DON indicated she had spoken with the Pharmacy and they reported it was up to the facility to review the transferred order in the new system. She indicated they immediately discontinued the orders and entered new order to specify the day of the week for the medications to be given. The admission order from a skilled nursing facility and May 2023 MAR prior to the electronic record company switch provided by the DON on 8/16/2023 at 4:00 PM. indicated the medications were administrated as ordered prior to 5/23/2023. The hospital ER records provided by the DON on 8/16/2023 at 4:00 P.M., indicated patient type was Observation, for accidental overdose. The hospital discharge papers included a list of current medications to be given and when next dose was due. The new prescription (Rx) leucovorin 15 mg tablet, give 1 tablet every 6 hours for 2 days. for methotrexate overdose. Next dose 6/1/23 at 6:00 P.M., then 12 A.M., 6 A.M., and 12:00 P.M. 2. A record review for Resident C began on 8/16/23 at 1:00 P.M., indicated diagnoses included dementia with behavioral disturbances, atrial fibrillation, abdominal aortic aneurysm, chronic kidney disease, long term use of anticoagulants (blood thinner.) Review of Resident C's Service Plan, dated		Wellness Director/designee will review all orders that have been processed on a daily basis for the previous twenty-four hours and seventy-two hour look back at the beginning of the week. All findings will be reviewed at the Weekly Wellness Committee Meetings for further review and recommendations for the next six months or until 100 % compliance has been achieved for three consecutive months. -	

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	2/25/2023 indicated the resident required staff attention (reminders or administration) to take medications. Review of State reported incident indicated on 6/15/2023 at 1:20 P.M., Resident C was administered another resident's medications. The medications administered were aspirin (antiplatelet, blood thinning properties) 81 mg and Lexapro (antidepressant) 20 mg. QMA 1 reported to the nurse she had given medications to the wrong resident. The NP was notified and an order was given to hold (not give) the Eliquis that day. The Psych NP was also notified and no new orders were given at that time. The MARs were reviewed for residents' pictures in the system. A follow up report added on 6/16/2023 indicated QMA 1 would work as an aide until retrained. Nurses would retrain QMA 1on the 6 rights of medication pass to ensure proper retraining of QMA 1. The orders indicated Resident C had an order for Eliquis 2.5 mg tablet, 1 tablet po twice daily for atrial fibrillation and long term use of anticoagulants. The order date was on 6/1/2023 with a start date of 5/23/2023. There were no orders for aspirin 81 mg or Lexapro 20 mg. to be administered. Review of the June 2023 MAR indicated Eliquis 2.5 mg 1 tablet was administered on at 8:00 A.M. and at 6:00 P.M. Review of Resident C's progress note dated 6/15/2023 at 2:20 PM, indicated a family member was notified of the medication error and an order received from the NP to hold Eliquis 2.5 mg due to the actions of one of the medications given-] aspirin 81 mg.			

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	In an interview on 8/16/23 at 3:40 P.M., the DON indicated QMA 1 was a new employee and had not payed attention to the resident's name. She indicated Resident C resided in the memory unit, both residents had the same first name and Resident C was given the other resident's medications. She indicated when the residents' MARs were reviewed, pictures of both residents were on the June MAR and records. She indicated the Nurse on duty finished the shift medication administration that day. QMA 1 was then assigned to work as a CNA, was educated, and being retrained. The DON indicated QMA 1 was not receptive to the re-training and quit working at the facility within 2 weeks of the incident. 3. Resident D's record review began on 8/16/2023 at 1:40 P.M., diagnoses included atrial fibrillation, acute pancreatitis, polycystic kidney disease, history of breast cancer. A review of Resident D's Service Plan dated 11/30/2023 indicated the resident required staff attention (reminders or administration) to take medications. Review of State reported incident indicated on 8/10/2023 at 9:01 A.M., Resident D was administered medications QMA 4 previously administered that morning due to QMA 2 being late to work. The medication had not been documented on Resident D's August 2023 MAR as having been given. LPN 3 had informed QMA 2, QMA 4 had given some of the morning medications to her residents. The NP was notified, was in the facility at the time and assessed the resident. The family was notified of the medication error. The QMAs were in-serviced on			

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	medication adminisration documentation. The follow-up was added on 8/14/2023 and indicated there no adverse reactions or side effects from the additional medication for Resident D. The August MAR indicated Resident D had multiple morning medications to be administrated daily. Administration of 8:00 A.M. medications on 8/10/2023 included the following medications: Acetaminophen (for pain) 500 mg 2 tablets; Amlodipine (for high blood pressure) 5 mg 1 tablet; Calcium (supplement) 600 mg 1 tablet; Daily Vitamin (supplement) 1 tablet; Fluoxetine (for depression) 10 mg 1 capsule; Folic Acid (supplement) 1 mg 1 tablet; Lidocaine Pad 5% applied to right knee; Pantoprazole (for pancreatitis) 40 mg 1 tablet; Prednisone (a corticosteroid using for polycystic kidney) 5 mg 1 tablet; Tacrolimus (for polycystic kidney) 1 mg 1 capsule; Tramadol (a narcotic for pain) 50 mg 1 tablet; Vitamin D3 (supplement) 400 units 1 tablet; and Carvedilol (for atrial fibrillation) 12.5 mg 1 tablet. These medications were only documented as administered 1 time for the 8:00 A.M. dose. Resident D's progress note dated 8/10/2023 at 11:15 AM indicated oncoming QMA 2 gave medications to the resident after being told the medications were given while QMA 4 was on duty and QMA 4 was in process of signing them out. -On 8/10/2023 at 12:02 P.M. indicated a message was left for family about the incident. -On 8/10/2023 at 8:46 P.M. blood pressure was 107/69, the NP indicated to hold Carvedilol 12.5 mg if SBP (systolic blood pressure, which is the upper number of the blood pressure) is under 110. -On 8/10/2023 at 9:09 P.M., Resident D was resting			

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	in bed. Denied pain or discomfort. There were no signs or symptoms of adverse reactions from the medication error, Blood pressure 107/69, pulse 98, respirations 17 and temperature 96.6 degrees. In an interview on 8/16/2023 at 3:45 P.M., the DON indicated the QMAs and Nurses were not to pre-set up residents medications. She indicated QMA 2 had come into work late on 8/10/23 and the residents were asking for their medications. QMA 4 set up the medications on the medication cart assigned to QMA 2 and administered the medications as residents came during breakfast. The DON indicated when QMA 2 come into work, LPN 3 had informed QMA 2 to only give the pre-setup medications labeled in the medication cart because QMA 4 had already administered all other morning medications on her medication cart. The DON indicated QMA 4 had not documented the medications were given when administered and was signing off the medications after the morning medication pass. QMA 2 gave Resident D their morning medications again because they were not signed off as given on the MAR. The DON indicated Resident D was later found to have taken the medications again when QMA 2 gave them to her. The DON indicated all staff involved would receive re-education. QMA 2 worked part time and had not worked since the incident to receive re-education. She indicated it was the policy of the facility to not pre-set up medications, and to document on the MAR at the time of administration of the medication. The facility's in-service education included a power point slide printed document provided by the DON on 8/16/2023 at 5:50 P.M. The DON indicated this education was given to the QMAs on 3/27/2023 and again on 8/11/2023. The education included the QMA Scope of Practice,			

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	QMA Responsibility, General Medication Preparation, Assistance, Administration and Observation and Documentation requirements. The power point slide indicated, "Administration: Medications are to be administered according to physicians orders...Medications are administered at the time they are prepared. NO PRE-Pouring, Pre-popping...The person who prepares medications is the person who administers. Residents should be identified prior to giving medications....Documentation: The person who administers the medication is who documents in the MAR/EMAR (electronic MAR)...." A current facility policy provided by the DON on 8/16/2023 at 5:50 P.M., titled, Medication Administration had a review date of 4/11/2022 indicated, "...Administration:...2. Medications are administered in accordance with written orders...4. Medications are administered at the time they are prepared. Medications are not pre-popped or prepoured...6. The person who prepares the dose for administration is the person who administers the dose. 7. Residents are identified before medication is administered. Methods of identifications include: b. checking photograph attached to medical record. c. calling resident by name. d. If necessary, verifying resident identification with other facility personnel...Documentation: 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented...." This State Tag relates to Complaint IN00414448.			