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	03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WICKSHIRE FORT HARRISON	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00402522. Complaint IN00402522-Deficiencies related to the allegations are cited at R0241 and R0295. Survey dates: March 6 and 7, 2023 Facility number: 014109 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on March 14, 2023	R 0000	ISDH Attn: Brenda Buroker Director of Division of Long Term Care 2 North Meridian Street Indianapolis, IN 46204 Re: Complaint Survey Wickshire Fort Harrison 8025 Doubleday Drive Indianapolis, IN 46216 Dear Ms. Buroker, On March 6, 2023, a State Residential Licensure with a complaint (#402522) was conducted at the above referenced facility by the Division of Long Term Care. Please find the Statement of Deficiencies with our facility's Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction. Please feel free to call me with any further questions at 317-546-2846.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Deig	Executive Director	03/21/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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			Respectfully submitted, John Scott Deig Executive Director Wickshire Fort Harrison	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents reviewed for medication receipt was observed by facility staff member to actually consume a narcotic medication when it was provided to the resident by the facility staff member. (Resident C) Findings include: During a medication administration observation on 3-6-23 at 12:55 p.m., with QMA 4, she obtained Resident C's medication of hydrocodone-apap 7.5/325 milligrams (mg) from the double locked medication cart, after speaking with Resident C who requested the medication for low back and left lower extremity pain. When QMA 4 took the medication to the resident's room, she handed the resident her medication, a white tablet, in a clear plastic cup. QMA 4 was observed to exit the room without observing the resident take the medication. During an interview at this time, Resident C picked up a clear plastic cup from the table adjacent to her recliner and demonstrated she still had the cup with the white pill in it that	R 0241	1. Immediate actions taken for those residents identified Education with QMAs, including Medication Administration policy review, completed by HWD 2. How the facility identified other residents Any resident residing in the facility had the potential to be affected. 3. Measures put into place/system changes Medication pass observation audit to be completed by HWD/designee weekly for 4 weeks, then monthly for 3 months. 4. How the corrective actions	03/08/2023

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	she had received from QMA 4 and indicated, "I will take this pill the Q brought me, when you came in, around 3 this afternoon." Resident C indicated she has a routine of receiving the narcotic pain medication "around 7 am or 7:30 a.m., and take it then, then get it around 1:00 [p.m.] and save it to take around 3 p.m., and then they bring it to me around 7:30 p.m., and I take it between 9:30 and 10 p.m." Resident C was unable to provide a time line of how long this routine had been going on. A review of the physician medication orders and nursing progress notes indicated an order for hydrocodone-acetaminophen 7.5/325 mg was written on 2-9-23 with instructions to be given four times daily PRN [as needed] for low back pain. At this time, additional clarification was obtained from Resident C's facility nurse practitioner to discontinue the previous orders for Tramadol [pain medication] orders for both scheduled and prn orders. Additional progress notes, dated 2-9-23 at 1:44 p.m., indicated the Wellness Director (WD) contacted the prescriber, a pain management physician, for clarification on the timing of the medication administration. The progress notes indicated the specialist clarified the medication is to be administered every 6 hours as needed for pain. In an interview with the Wellness Director (WD) on 3-6-23 at 2:33 p.m., she indicated she has addressed with the QMA's that they are to actually observe each resident take their medication, not just leave the medications with the person to take later, unless they have been assessed to be able to do so. In an interview with the WD on 3-7-23 at 9:40 a.m., she indicated she had spoken with QMA 4 and		will be monitored The HWD/designee will be responsible for compliance. Any issues identified will be immediately addressed.	

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	the reason she provided for not observing the resident actually consume the pain medication was aware the resident wished to speak with the surveyor and she did not want to interfere with that. "I told her she needed to remember it is 'Med Pass 101' that if you are the person that prepared the med, you are the one that is responsible to give the med and make sure the person took the med." On 3-7-23 at 11:35 a.m., the WD provided a copy of a policy entitled, "Pharmaceutical Services," with an effective date of 11-1-19. This policy indicates, "It is the policy of Wickshire Senior Living to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana, under the direction of the Health and Wellness Director/designee...Medications will be administered by licensed nursing personnel or qualified medication aides." This Residential tag is related to Complaint IN00402522. 2.5-4(e)(1)			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview and record review, 1 of 3 residents reviewed for medication receipt, an observation of multiple OTC (over-the-counter) medications were observed in her room in an unsecured manner. This resident had been assessed to not be able to self-administer her medications. (Resident C)	R 0295	1. Immediate actions taken for those residents identified OTC medications placed in a discreet location.	03/24/2023

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	Findings include: During a medication pass observation on 3-6-23 at 12:55 p.m., with Resident C, multiple OTC medications were observed unsecured in her apartment. Resident C was seated in a recliner with a table adjacent to her recliner, with the following medications observed in a shoebox: -"Nerve Control 911." (An over the counter [OTC] medication) -Cetirizine 10 mg. (OTC allergy medication) -"Peak PS." (OTC) -"Flora Food," "probiotic." (OTC) -Generic Flonase nasal spray 50 mcg. (OTC allergy medication) -nitroglycerin 0.4 mg take 1 tablet every 5 minutes up to 3 times for chest pain as needed (prescription medication for angina/chest pain). The resident was reluctant to allow the medications to be reviewed in detail, only allowing a brief review of the front label for name recognition. Additionally, an estimated 25 or more OTC medications were observed on a shelving unit, located behind the resident's recliner, but the resident declined to allow the medications to be reviewed. None of these medications were secured in any manner, beyond her entry door being locked. Review of Resident C's most recent "Self-Administration of Medications Review" form, dated 1-20-23, indicated she is not physician-ordered to be able to self-administer her medications and "resident prefers staff to administer medications." The WD indicated Resident C has a diagnoses of dementia and paranoia, as well as a history of		2. How the facility identified other residents This resident was the only resident affected. 3. Measures put into place/system changes OTC medications placed in a wardrobe-size cabinet with a lock. 4. How the corrective actions will be monitored HWD or designee will audit for security weekly for 4 weeks, then monthly for 3 months	

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	keeping medications in her room for some time now. She indicated Resident C is a retired healthcare worker and "seems to feel like she is capable of handling her own meds. The problem with that is she sometimes becomes somewhat forgetful and doesn't remember to do certain things...I have had to be the bad guy several times by gathering all the unsecured meds in her room. As you can imagine, this did not go over very well. I've tried to approach it from the standpoint of safety. I didn't realize she had a bunch of OTC's in her room again." The WD indicated Resident C has a history of ordering medications from an on-line purchasing source. "Due to her forgetfulness at times and not keeping her meds secured, she has been assessed not to self-administer her own meds. [Name of Resident C] has been displaying some paranoia recently." On 3-7-23 at 11:35 a.m., the WD provided a copy of a policy entitled, "Pharmaceutical Services," with an effective date of 11-1-19. This policy indicates, "It is the policy of Wickshire Senior Living to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana, under the direction of the Health and Wellness Director/designee. Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents." This Residential tag relates to Complaint IN00402522. 2.5-6(a)			