STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	02/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00427568 and IN00428003. Complaint IN00427568 - Federal/ State deficiencies related to the allegations are cited at F0755. Complaint IN00428003- No deficiencies related to the allegations are cited. Survey dates: February 19 and 20, 2024 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 104 Total: 104 Census Payor Type: Medicare: 3 Medicaid: 83 Other: 18 Total: 104 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 27,2024	F 0000		
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its			

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

Melanie Sigler | Director of Nursing | 03/08/2024

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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	residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview, and record review, the facility failed to timely obtain medications from the pharmacy, to accurately document administration of medications, and to timely obtain pain medication from the emergency drug supply for 3 of 4 residents reviewed for medication availability. (Resident B, D, and H). Findings include:	F 0755	**F755** **Corrective actions accomplished for those residents found to be affected by the alleged deficient practice:** No residents were harmed by the deficient practice. Residents B, D, and H's	03/10/2024

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	1. The clinical record for Resident B was reviewed on 2/19/24 at 11:15 a.m. The Resident's diagnosis included, but were not limited to, quadriplegia (loss of movement of all 4 limbs) and anoxic (lack of oxygen) brain injury. A care plan, initiated 5/5/22, indicated Resident B had impaired cognitive function due to a head injury. The goal was for all areas of care to be met by staff. The interventions included, but were not limited to, administer medications as ordered, initiated 5/5/22, communicate with resident, family, and caregivers regarding his capabilities and needs, initiated 5/5/22. A Quarterly MDS (Minimum Data Set) Assessment, completed 12/13/23, indicated he rarely/ never made himself understood and rarely/never understood what was said. He had long and short-term memory problems and was dependent on staff for all ADL (Activities of Daily Living). A physician's order, dated 12/30/23, indicated Resident B was to receive Methylphenidate (stimulant medication) 5 mg (milligram) once daily for hypersomnolence (excessive sleepiness). The MAR (Medication Administration Record) for January 2024 indicated that Resident B received his methylphenidate 5 mg at 9:00 a.m. daily from 1/6/24 through 1/31/24. A Controlled Drug Administration Record for the methylphenidate 5 mg indicated the pharmacy had delivered 10 tablets on 12/31/23, and the tablets had been signed off as administered from 1/1/24 through 1/11/24.		medications were reconciled immediately. **Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: All admissions/readmissions have the potential to be affected.** All residents have the potential to be affected. The facility conducted a full house mar to cart audit. Any medications unavailable were immediately reordered. **Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur:** Education has been provided to all licensed nurses and qualified medication assistances utilizing the Ordering and Receiving Controlled and Non-Controlled Medications policy with emphasis on ordering refills of medication in a timely manner and pulling available medication from the E.D.K. **How the corrective measures will be monitored to ensure the alleged deficient practice does not recur:**	

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	A Controlled Drug Administration Record for the methylphenidate 5 mg indicated the pharmacy had delivered 10 tablets on 1/21/24, and the tablets had been signed off as administered from 1/22/24 through 1/31/24. The clinical record did not contain a Controlled Drug Administration Record for methylphenidate 5 mg for the date of 1/12/24 through 1/21/24. During an interview on 2/19/24 at 11:15 a.m., FM (Family Member) 2 indicated that Resident B had not received his methylphenidate for 14 or 15 days during the month of January 2024. FM 2 had been told that there was some sort of billing error and that the medication had not been sent from the pharmacy. During an interview on 2/19/24 at 2:55 p.m., the DNS (Director of Nursing Services) indicated that Resident B did not receive his methylphenidate during the time frame of 1/12/24 through 1/22/24. There had been a billing issue and the pharmacy had not notified her of the problem. The nursing staff had continued to sign off the medication as given, even though it was not available, and had not informed her that the medication was not available. The DNS had fixed the issue as soon as she was notified. The DNS was unsure why the nursing staff continued to sign off the medication as given. 2. The clinical record for Resident H was reviewed on 2/20/24 at 10:20 a.m. The Resident's diagnosis included, but were not limited to, uterine cancer and anxiety. A care plan, initiated 7/26/23, indicated she had complaints of acute and chronic pain. The goal		The DON/Designee will complete a mar to cart audit on all new admits/readmits this will be an ongoing practice. The following audit for 10 residents will be conducted by the Director of Nursing Services or designee 2 times per week times 8 weeks, then monthly times 4 months to ensure compliance: Mar to Cart Audit **The results of the audit observations will be reported, reviewed and trended for compliance thru the facility Quality Assurance Committee for a minimum of six months then randomly thereafter for further recommendations.**	

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	was for her to verbalize relief of pain. The interventions included, but were not limited to, observed for pain every shift, initiated 7/26/23, and provide medications per order, monitor for side effects and evaluate effectiveness of medications, initiated 7/26/23. A Quarterly MDS Assessment, completed 11/10/23, indicated Resident H was cognitively intact, she received scheduled pain medications and had pain almost constantly. She received opioid medication. A physician's order, dated 1/21/24, indicated she was to receive oxycodone er (extended release) 10 mg every 12 hours for pain. The February 2024 MAR indicated she has received her oxycontin er 10 mg every 12 hours from 2/1/24 through 2/19/24 at 9:00 a.m. A physician's order, dated 2/19/24, indicated Resident H was to receive oxycodone ed 10 mg every 12 hours for pain. The February 2024 MAR indicated she had not received her oxycodone as scheduled on 2/19/24 at 9:00 p.m., and 2/20/24 at 9:00 a.m. During an interview on 2/20/24 at 10:20 a.m., Resident H indicated that the facility had run out of her pain medications, and she was waiting for them to come in from the pharmacy. This happened constantly. On 2/20/24 at 10:30 a.m., an interview was conducted with LPN (Licensed Practical Nurse) 3 and LPN 4. LPN 3 indicated that Resident H's oxycodone er 10mg had not come in from the pharmacy yet and the dose was not available in			

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	the emergency drug supply at the facility. LPN 4 indicated that she would have them delivered from the pharmacy stat (right away) and that her normal routine was to reorder the medications that residents received routinely at least 2 days before the medication was going to run out. During an interview on 2/20/24 at 12:25 p.m., Pharmacist 6 indicated the refill request for Resident H's oxycodone er 10 mg had been received at the pharmacy on 2/20/24 at 12:25 a.m. The medication was scheduled to be delivered to the facility on the evening of 2/20/24. 3. The clinical record for Resident D was reviewed on 2/20/24 at 10:10 a.m. The Resident's diagnosis included, but were not limited to, depression and low back pain. A care plan, last revised on 7/13/23, indicated Resident D had complaints of chronic pain. The goal was for her to be able to verbalize relief of pain. The interventions included, but were not limited to, observe for pain every shift, initiated 12/8/22 and for pain management consultation, initiated 12/8/22. An Annual MDS Assessment, completed 12/14/23, indicated she was cognitively intact and received scheduled and as needed pain medications. The February 2024 MAR indicated Resident D had received scheduled Hydrocodone-Acetaminophen 5-325 mg every 4 hours for moderate to severe pain daily. The February 2024 MAR indicated it had been administered as ordered with the exception of on 2/2/24 at 8:00 a.m., 2/12/24 at 8:00 a.m. and 12:00 p.m., and 2/20/24 at 8:00 a.m.			

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	During an interview on 2/20/24 at 10:10 a.m., Resident D indicated she had not received her morning dose of Hydrocodone because she was out of medication. She had received a dose at 4:45 a.m., but had not had another dose since then, and the pharmacy needed to deliver the medication to the facility. During an interview on 2/20/24 at 12:18 p.m., Resident D indicated she still had not received any of her scheduled pain medication. She was experiencing some pain but was pushing through it. She had received some Tylenol which was taking the edge off. During an interview on 2/20/24 at 12:20 p.m., the UM (Unit Manager) indicated that Resident D's Hydrocodone-Acetaminophen had not been delivered from the pharmacy as yet, but a two-shift supply was available for Resident D from the emergency drug supply. During an interview on 2/20/24 at 12:21 p.m., QMA (Qualified Medication Aide) 7 indicated that she had not administered the 8:00 a.m. scheduled Hydrocodone- Acetaminophen because it was not available on the medication cart. QMA 7 had given Resident D Tylenol instead. She wasn't aware of being able to get the medication out of the emergency drug supply. LPN 8 had just informed her that she was able to get the medication for QMA 7 to administer. During an interview on 2/20/24 at 12:35 p.m., the DNS indicated that she was unaware that Resident H and Resident D had not received there scheduled pain medications. She was unsure why the pharmacy had not delivered the scheduled oxycodone. Resident D's hydrocodone should			

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	have been administered timely from the emergency drug supply. On 2/20/24 at 1:03 p.m., the DNS provided the Ordering and Receiving Non-Controlled Medications Policy, last revised August 2020, which read "...Medications and related products are received from the pharmacy on a timely basis. The facility maintains accurate records of medications order and receipts...Reordering of medications is done in accordance with the order and delivery schedule established by the pharmacy provider. Quantities of medications sent from the pharmacy may vary in accordance with payor status, insurance plan, or law...Reorder medications based on estimated refill date [ERD] on the pharmacy Rx [prescription] label, or at least three days in advance, to ensure an adequate supply is on hand. When ordering medication that requires special processing, order at least seven days in advance of need...After hours, medications should be ordered as outlined in the Emergency Pharmacy Service and Kits Policy..." This citation relates to Complaints IN00427568. 3.1-25(g)(3)			