STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RIVER CROSSING ASSISTED LIVING COMMUNITY	2400 MARKET ST CHARLESTOWN, IN 47111

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00408817, IN00408888, IN00408533, and IN00404653. Complaint IN00408817 - State deficiency related to the allegations are cited at R0041, R0064, R0090, R0241, R0247, and R0349. Complaint IN00408888 - State deficiency related to the allegations are cited at R0041, R0064, R0090, and R0349. Complaint IN00408533 - No deficiencies related to the allegations are cited. Complaint IN00404653 - No deficiencies related to the allegations are cited. Survey dates: May 23 and 24, 2023. Facility number: 012007 Residential Census: 95 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 6, 2023.	R 0000		
R 0041 Bldg. 00	410 IAC 16.2-5-1.2(o)(4) Residents' Rights - Deficiency (4) The facility shall develop and implement policies for investigating and responding to complaints when made known and grievances made by: (A) an individual resident; (B) a resident council or family council, or			

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

Rich Pedersen | Executive Director | 06/26/2023

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	both; (C) a family member; (D) family groups; or (E) other individuals. Based on record review and interview, the facility failed to ensure allegations of unusual occurrences were thoroughly investigated and reported to appropriate authorities for 1 of 3 residents reviewed for incident reporting and investigation. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/23/23 at 11:30 a.m. The diagnoses included, but were not limited to, major depressive disorder and multiple sclerosis. The physician's order, dated 3/14/22, indicated the resident received diazepam 10 mg (milligrams) every 6 hours as needed for anxiety. The resident's Controlled Drug Use Record sheet for diazepam 10 mg indicated the medication was signed out as administered by QMA (Qualified Medication Aide) 3 on 24 different occasions between 3/20/23 and 5/11/23. Each occurrence had either the initials of LPN 4 or the ADON (Assistant Director of Nursing) as a co-signer for the administrations. The handwritten statement of LPN (Licensed Practical Nurse) 4, dated 5/16/23, indicated on 4/12/23 the nurse noticed QMA 3's behavior was not ordinary for him. He had increased confusion; he was leaving his medications on top of his medication cart and was late on his medication pass. He was slurring his words. The nurse informed the DON (Director of Nursing) of his behaviors. At shift change that evening, she	R 0041	R 041 410 IAC 16.2-5-1.2(o)(4) Resident's Rights Deficiency *The facility failed to ensure allegations of unusual occurrences were thoroughly investigated and reported to appropriate authorities for 1 of 3 residents reviewed for incident reporting and investigation.* **Corrective actions for resident that was affected by the alleged deficient practice:** Allegation was investigated and missing medication was reported to local authorities by ED. **Other residents having the potential to be affected by the said deficient practice:** All residents have the potential to be affected by the alleged deficient practice. **Measures put into place to ensure that the alleged deficient practice does not occur:** ED, DON, and ADON were re-educated by Regional Nurse regarding incident reporting, investigation guidelines, and state reporting requirements on **6/15/2023**. Staff will be re-educated regarding reporting and investigations.	06/21/2023

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	noticed a bottle of Ativan was missing when counting narcotics. She brought it to the DON's attention. The nurses, the DON, and the ED (Executive Director) started looking for the bottle of Ativan. QMA 3 found the bottle in the medication room. On the next day, QMA 3's behavior was worse. LPN 4 brought it to the DON's attention, who spoke with QMA 3 and sent him home for the remainder of the day. When LPN 4 took over the medication cart, she noticed Resident B's Valium (diazepam) was signed out more frequently than the resident usually received them. Most of his Valium tablets were signed out by QMA 3. Upon assessing the narcotic sheet, LPN 4 realized her initials were signed by someone else behind QMA 3. On eight of the instances, where her initials were signed, she had not even worked on those days. She informed the DON of her findings. The DON's handwritten statement, dated 5/16/23, indicated she was informed by the ED and ADON of medication being signed out by QMA 3. QMA 3 was questioned, and the investigation was initiated. No floor nurses had informed her, only the ED and ADON. The report was sent to State, and a text was sent to all staff of the scope of practice and to know what their's was. During the resident interview, dated 5/16/23 at 3:00 p.m., conducted by the ED (Executive Director), the resident indicated he took only one dose of his Valium every 2 to 3 weeks and only at nighttime. He did not take any during the summer. He did take it during storms at night. It was always after 4:00 p.m., never in the morning. The last time he had taken it was a few weeks prior to the interview date. The facility staff informed the resident they found a discrepancy with his medication and would be replacing the missing		**How the corrective actions will be monitored to ensure the deficient practice will not recur.** DON, or ADON will maintain a log of ALL occurrences and review weekly to validate that investigation & reporting policy was followed. Discrepancies will be immediately addressed. The process will be on-going.	

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	medication. During an interview with the ED on 5/24/23 at 8:57 a.m., he indicated he believed he was informed on the 16th of May. The only concerns he had heard about prior, was that QMA 3 had some sweating issues, that some staff were concerned about. QMA 3 told the DON some of the things he was doing in his personal life as far as working out and weight loss and one of the side effects was sweating, so they didn't think much about it. He was not aware of any concerns with narcotics with him until the 16th of May. He was unable to interview or get a statement from QMA 3 despite multiple attempts. They did not notify the authorities. There was no police report. They probably should have reported it, but they did not. They would notify authorities when there was misappropriation, and every other time he had reported those. Every time he called them in, they said they couldn't do anything about it. Honestly, it slipped his mind. During an interview on 5/24/23 at 9:16 a.m., LPN 4 indicated she had reported concerns of drug use for QMA 3 back in April and administration had let it go on that long. On 4/12/23 she saw the QMA not acting right. He was always a bit late every morning, but he made silly mistakes. Leaving medications on the cart and spilling things. He used to be punctual, but it was taking him until 9:30 a.m. or 10:00 a.m. to finish his medication pass, when usually he would be done by around 8:30 a.m. When the DON and ADON came in she told them something was not right. The ADON said that was just how QMA 3 was, and nothing was done. The next day his behavior was worse, and she again told the DON and the ADON. On 4/13/23, she observed all the Valium being signed out abnormally and she told the			

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	DON and the ADON about it. She told them verbally in person. Nothing was done until last week when she mentioned it to them again. On April 13th she informed the DON and ADON that she thought it was unusual QMA 3 was signing them out. She brought it to their attention again last week. That was when they got the investigation going. She identified the other co-signing nurse's initials as the ADON. During an interview with the ADON on 5/23/24 at 9:41 a.m., she indicated she was the one who did the investigation on the incident. On the 4/12/23 of April she was notified QMA 3 was abnormally sweaty. On 4/13/23 she noticed he had abnormal behavior, almost like a rag doll type movement. He was very loose. The DON and herself took him out on the sidewalk and sent him home immediately the morning of 4/13/23. He said that his car had been stolen, he didn't get a lot of sleep, he and his boyfriend had broken up. QMA 3 suffered with depression or being upset, she did not know his actual diagnoses, but he had suffered with mental issues previously. Him being abnormally sweaty did not mean anything to her. He took pre-workout and was running around the building. When they noticed a bottle of Ativan missing, they began to look for it. She was climbing into a dumpster to look for it when another staff member radioed that it had been in the medication cart inside of a Flonase medication box. They did not conduct any drug screening that she was aware of. There was no reason for anyone to believe anything was abnormal. She was not made aware of the diazepam concern until the 16th of May, which was when she started her investigation. After the QMA was sent home, an Agency Nurse had also told her that QMA 3 was acting abnormal. The nurse told her that she had a family member that was on drugs, and she felt like			

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	his behavior mimicked that sort of behavior. There was a rumor of paraphernalia after he was sent home. The rumors started flying. Everyone surmised what drugs he was on. He was sweaty so he must be speedy. They said that he was on methamphetamine and that he was carrying his backpack tightly. Then someone said they looked through his backpack. LPN 4 had said she had looked through his backpack and found drug paraphernalia in his backpack. She heard this around 4/14/23. They did not do drug testing because they still didn't have any reason to believe he was on drugs. He had reasons that supported his behavior, he had all the personal issues going on, and they thought it was his mental issues. They asked if he was on drugs, he said no, so they sent him home and told him to go rest. When he was asked to go home there was a diazepam that LPN 4 signed out to make the count correct. That day there was a discrepancy. They did not investigate the missing medication. When they asked the staff member to leave, he hadn't been able to sign out his medication pass. So, they corrected the count. There was a missing tablet. During an interview on 5/24/23 at 10:09 a.m., LPN 4 indicated she did witness paraphernalia in the facility. On 4/13/23, when his behavior was worse, she felt he was definitely on something. Something was not right with him. She went through his bag and found a clear pipe that looked like it had been smoked out of. She told both the DON and the ADON, she told them immediately after seeing the pipe. They didn't say anything to her, and no one called the police. That was the day he was sent home. They told her they sent him home to sleep it off. During an interview on 5/24/23 at 10:33 a.m., the			

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	DON indicated on 4/12/23, one nurse came to her and said QMA 3 had weird behavior. She said he was sweaty and carrying a backpack. So, they watched him. He was sweaty, he took pre-workout, phentermine, and drank energy drinks. She knew phentermine would make a person sweat, so would pre-workout, and it was warm in the building. He didn't seem weird to her. She didn't think the sweating was over excessive and he didn't appear to be guarding his backpack. She watched him the rest of the day, and he didn't do anything outside of the ordinary. He wasn't struggling to do anything. At the end of shift that day the Ativan came up missing when they went to do count. At that point everyone started looking for it. They were looking in the trash when someone found it in a Flonase box in the medication cart. At that point she told the ADON that was a little out of sorts for him and told her to talk to him in the morning. The next morning, she sent the ADON to talk to him and she returned saying it was not good. She told him to come outside with her and they talked. She asked what was going on because something was off. His body behavior was like he was exhausted. She questioned if he was using drugs. He said no. He still didn't appear to be under an influence. She asked what was going on. He said he hadn't slept in 24 hours, his car was stolen by his cousin, and he and his boyfriend had broken up. All together it was a whole lot. He had some past mental issues. She told him since he'd not slept in 24 hours to go home. She told him to get his stuff together, if he was bringing it into work, he was going to screw stuff up. They sent him home and agreed he was to return the following Tuesday so they could keep an eye on him. She was not made aware of a staff member observing a pipe. There was hearsay that someone went through his backpack. They kept saying he was guarding it,			

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	he always had it with him. She had heard that another staff member went through his bag. She could not remember how she heard it. She thought it was after they sent him home. It wasn't before all of it. She did not do any further investigation with it. They did not conduct a drug test. They had to have something more than a suspicion to conduct a drug test. They did not do random drug screening either. The day they sent him home he hadn't signed out all of his MARs (Medication Administration Records) yet and they did correct the count. And then the ADON texted her the day she found out about the Valium. They did not audit when the bottle of valium was missing or when the count had to be corrected. They did not call law enforcement. She didn't know why they didn't. She wasn't there when it all transpired. Corporate was notified, and they usually did notify law enforcement, but law enforcement usually wouldn't do anything. The reporting guidelines policy, last revised 5/2023, provided on 5/24/23 at 12:06 p.m. by the DON, included but was not limited to, "... The purpose of this guideline is to clarify the type of issues that require you to notify your Regional Nurse. This reporting should occur as soon as you are aware of the incident or issue... 2. Any issue required by your state agency to be reported. 3. Any allegation of abuse, neglect, or misappropriation... 15. Drug Diversions... 16. Significant Medication Errors... The Regional Nurse should be called with any situation that you might find questionable or that could result in negative outcome..." This State deficiency relates to Complaints IN00408817 and IN00408888			

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R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on record review and interview, the facility failed to ensure residents were free from misappropriation of narcotics for 1 of 3 residents reviewed for misappropriation. (Resident B) Findings include: The clinical record for Resident B was reviewed on 5/23/23 at 11:30 a.m. The diagnoses included, but were not limited to, major depressive disorder and multiple sclerosis. The physician's order, dated 3/14/22, indicated the resident received diazepam 10 mg (milligrams) every 6 hours as needed for anxiety. The resident's Controlled Drug Use Record sheet for Diazepam 10 mg indicated the following: -On 3/20/23 at 10:00 a.m. a dose of the medication was signed out by QMA (Qualified Medication Aide) 3 with the ADON's (Assistant Director of Nursing) initials beside it. -On 3/23/23 at 9:00 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. -On 3/25/23 at 7:00 a.m. a dose of the medication was signed out by QMA 3 with LPN (Licensed Practical Nurse) 4's initials beside it. -On 3/29/23 at 10:00 a.m. a dose of the medication was signed out by QMA 3 with the ADON's	R 0064	*R 064 410 IAC 16.2-5-1.2(hh) Resident's Rights* *The facility failed to ensure residents were free from misappropriation of narcotics for 1 (resident B) of 3 residents reviewed for misappropriation.* **Corrective actions for resident that was affected by the alleged deficient practice:** Resident B was informed of the event and his medication was replenished at the expense of the facility. **Other residents having the potential to be affected by the said deficient practice:** All residents who receive controlled substances from clinical staff have the potential to be affected. **Measures put into place to ensure that the alleged deficient practice does not occur:** Residents receiving controlled substances from clinical staff will be interviewed by ED, DON, or	06/21/2023

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	initials beside it. - On 3/30/23 at 9:00 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/1/23 at 12:00 p.m. a dose of the medication was signed out by QMA 3 with LPN 4's members initials beside it. - On 4/3/23 at 10:00 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/4/23 at 11:30 a.m. a dose of the medication was signed out by QMA 3 with LPN 4's members initials beside it. - On 4/6/23 at 6:30 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/6/23 at 2:00 p.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/8/23 at 10:00 a.m. a dose of the medication was signed out by QMA 3 with LPN 4's initials beside it. - On 4/9/23 at 9:00 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/24/23 at 9:00 a.m. a dose of the medication was signed out by QMA 3. There was no other staff member signature with the administration. - On 4/26/23 at 9:30 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/27/23 at 11:00 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/28/23 at an illegible time, a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 4/29/23 at 1:30 p.m., a dose of the medication was signed out by QMA 3 with the ADON's initials beside it.		designee by 6/14/2023 to ensure that they are receiving their medications as ordered. If they are not able to participate in the interview they will be assessed for the absence or presence of target symptoms of their controlled substance QMAs were re-educated regarding the scope of their practice by 6/15/2023. Nurses & QMAs were re-educated regarding the process for signing out narcotics on 5/31/2023 Narcotic inventory sheets will be separated by hallway & placed in binders along with daily narcotic count sheet so they are easily accessible to review by 6/15/2023 All staff were re-in serviced on abuse and resident's rights on 5/31/2023 **How the corrective actions will be monitored to ensure the efficient practice will not recur:** DON or designee will review narcotic binders 5 x's a week for 4 weeks to ensure daily count & inventory sheets are being signed and weekly thereafter. This will be an ongoing weekly process. ED, DON, & designee will do weekly random interviews x's 4 weeks with 3 residents who are receiving controlled substances from clinical staff to ensure they are getting their medications, then weekly with 1 resident x's 4	

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	- On 5/1/23 at 10:00 a.m., a dose of the medication was signed out by QMA 3 with LPN 4's members initials beside it. - On 5/6/23 at 9:00 a.m., a dose of the medication was signed out by QMA 3 with another LPN 4's initials beside it. - On 5/6/23 at 5:30 a.m., a dose of the medication was signed out by QMA 3 with another LPN 4's initials beside it. - On 5/7/23 at an illegible time, a dose of the medication was signed out by QMA 3 with LPN 4's initials beside it. - On 5/7/23 at 8:00 a.m., a dose of the medication was signed out by QMA 3 with LPN 4's initials beside it. - On 5/10/23 at 10:00 a.m. a dose of the medication was signed out by QMA 3 with the ADON's initials beside it. - On 5/11/23 at 6:00 a.m., a dose of the medication was signed out by QMA 3 with LPN 4's initials beside it. The handwritten statement of LPN 4, dated 5/16/23, indicated on 4/12/23 at shift change that evening, she noticed a bottle of Ativan was missing when counting narcotics. She brought it to the DON's attention. The nurses, the DON, and the ED (Executive Director) started looking for the bottle of Ativan. QMA 3 found the bottle in the medication room. On the next day QMA 3 was sent home for the remainder of the day. When LPN 4 took over the medication cart, LPN 4 noticed Resident B's Valium was signed out more frequently than the resident usually received them. Most of his Valium were signed out by QMA 3. Upon assessing the narcotic sheet, LPN 4 realized her initials were signed by someone else behind QMA 3. On eight of the instances where her initials were signed, she had not even worked on those days.		weeks. Results will be shared at QAPI, a stop date will be determined upon compliance.	

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	During the resident interview, dated 5/16/23 at 3:00 p.m., conducted by the ED the resident indicated he took only one dose of his Valium every 2 to 3 weeks and only at nighttime. It was very rare he took it during the day. He did take it during storms at night. It was always after 4:00 p.m., never in the morning. The last time he had taken it was a few weeks prior to the interview date. He had not taken his diazepam in the morning for the last month. The facility staff informed the resident they found a discrepancy with his medication and would be replacing the missing medication. During an interview on 5/24/23 at 9:16 a.m., LPN 4 indicated she informed the DON and ADON that she saw her initials being signed out on eight days she wasn't in the facility. There were multiple days signed off in her name that she was not working in the building. She reviewed at this time the Controlled Drug Use Record sheet and indicated the medication was signed out in her name on 3/25/23, 4/1/23, 4/18/23, twice on 5/6/23, twice on 5/7/23, and again on 5/11/23. The 5/11/23 one was extremely unusual because it was signed out for 6:00 a.m. QMA 3 was never on time and they never got the keys right at 6:00 a.m., it was always 6:15 a.m. or later. She was not there on any of those occasions where her initials were cosigned. She had never once been asked to sign for the resident's Valium. She had never co-signed on any administrations of Valium for the resident. Of the ten times on the sheet, she attested she signed none. On 4/13/23 she informed the DON and ADON that she thought it was unusual QMA 3 was signing them out. She identified the other co-signing nurse's initials as the ADON. During an interview with the ADON on 5/23/24 at			

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	9:41 a.m., she indicated when they noticed a bottle of Ativan missing, they began to look for it. She was climbing into a dumpster to look for it when another staff member radioed that it had been in the medication cart inside of a Flonase medication box. She was not made aware of the diazepam concern until the 16th of May, which was when she started her investigation. After he was sent home on 4/13/23 there was a discrepancy with the narcotics. When they asked the staff member to leave, he hadn't been able to sign out his medication pass. So, they corrected the count. There was a missing tablet. She had not ever signed out or co-signed the medication. She attested the initials were hers and he had used their initials and just wrote them on the sheet. She believed he forged their signatures. She had worked there 2 years and she believed he had asked for it one time during that time frame from her. During an interview on 5/24/23 at 10:33 a.m., the DON indicated at the end of shift on 4/12/23 the Ativan came up missing when they went to do count. At that point everyone started looking for it. They were looking in the trash when someone found it in a Flonase box in the medication cart. She viewed the narcotic sheet and indicated the initials were supposed to be the ADON's initials, but she indicated she'd never signed the medication out before. The Controlled Substance Policy, last revised 10/2022, provided on 5/24/23 at 12:06 p.m. by the DON, included, but was not limited to, "... 5. Any discrepancy in the inventory of a controlled substance is to be reported to the Director of Nurses immediately. The Director of Nurses is responsible for investigating and making a reasonable effort to reconcile all reported			

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	discrepancies. The discrepancy of a controlled substance is to be reported to the Administrator and the Regional Nurse immediately. If a discrepancy is not reconciled, the Director of Nurses is to document the details on the audit record, including all possible shift or persons responsible for the discrepancy, and the efforts made to reconcile it..." The Abuse, Prevention and Prohibition Policy, last revised 10/2022, provided on 5/24/23 at 12:06 p.m. by the DON, included but was not limited to, "... Each resident has the right to be free from abuse... Investigation... Misappropriation of Resident Property is defined as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent..." This State deficiency relates to Complaints IN00408817 and IN00408888.			
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings;			

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	(C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request			
	Based on record review and interview, the facility failed to ensure administration appropriately responded to and reported allegations of unusual occurrences for 1 of 3 residents reviewed for Administration and Management of the facility. (Resident B) Findings include:	R 0090	*R 090 410 IAC 16.2-5-1.3 (g) (1-6) Administration & Management* The facility failed to ensure administration appropriately responded to and reported allegations of unusual occurrences for 1 (Resident B) resident.	06/21/2023

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	During an interview with the ED on 5/24/23 at 8:57 a.m., he indicated the only concerns he had heard about prior to 5/16/23 was that QMA 3 had some sweating issues that some staff were concerned about. He was not aware of any concerns with narcotics with him until the 5/16/23. They did not notify the authorities. There was no police report. They probably should have reported it, but they did not. They would notify authorities when there was misappropriation, and every other time he had. Every time he called them in, they said they couldn't do anything about it. Honestly it slipped his mind. During an interview on 5/24/23 at 9:16 a.m., LPN 4 indicated she had reported concerns of drug use for QMA 3 back in April and administration had let it go on that long. On 4/12/23 she saw the QMA not acting right. When the DON and ADON came in she told them something was not right. The ADON said that was just how QMA 3 was, and nothing was done. The next day his behavior was worse, and she again told the DON and the ADON. On 4/13/23, she observed all the Valium being signed out abnormally and she told the DON and the ADON about it. She told them verbally in person. Nothing was done until last week when she mentioned it to them again. On 4/13/23 she informed the DON and ADON that she thought it was unusual QMA 3 was signing them out. She brought it to their attention again last week. That was when they got the investigation going. During an interview with the ADON on 5/23/24 at 9:41 a.m., she indicated on 4/12/23 she was notified QMA 3 was abnormally sweaty. On 4/13/23 she noticed he had abnormal behavior. The DON and herself took him out on the		**Corrective actions for resident that was affected by the alleged deficient practice:** Allegation was investigated and missing medication was reported to local authorities by ED. **Other residents having the potential to be affected by the said deficient practice:** All residents have the potential to be affected by the alleged deficient practice. **Measures put into place to ensure that the alleged deficient practice does not occur:** ED and DON were re-educated by Regional Nurse regarding incident reporting, significant events, and investigations. Staff was re-educated regarding reporting and investigations. **How the corrective actions will be monitored to ensure the efficient practice will not recur** ED, DON, & ADON will monitor incidents daily to ensure that the facility's policy for significant events was followed. Discrepancies will be immediately addressed. Weekly incidents will be sent to Regional Nurse and reviewed weekly during the regional risk call. This will be an on-going process.	

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	sidewalk and sent him home immediately the morning of 4/13/23. After the QMA was sent home on 4/13/23 an Agency Nurse had also told her that QMA 3 was acting abnormal. LPN 4 had said she had looked through his backpack and found drug paraphernalia in his backpack. She heard this around 4/14/23. They did not do drug testing because they still didn't have any reason to believe he was on drugs. They asked if he was on drugs, he said no, so they sent him home and told him to go rest. During an interview on 5/24/23 at 10:33 a.m., the DON indicated on 4/12/23, one nurse came to her and said QMA 3 had weird behavior. The next morning, she sent the ADON to talk to him and she returned saying it was not good. She told him to come outside with her and they talked. She questioned if he was using drugs. He said no. She was not made aware of a staff member observing a pipe. She did not do any further investigation with it. They did not conduct a drug test. They had to have something more than a suspicion to drug test. They did not do random drug screening either. The day they sent him home he hadn't signed out all his MARs (Medication Administration Records) yet and they did correct the count. And then the ADON texted her the day she found out about the Valium. They did not audit when the bottle of valium was missing or when the count had to be corrected. They did not call law enforcement. She didn't know why they didn't. She wasn't there when it all transpired. Corporate was notified. They usually did notify law enforcement, but law enforcement usually wouldn't do anything. The Abuse, Prevention and Prohibition Policy, last revised 10/2022, provided on 5/24/23 at 12:06 p.m. by the DON, included but was not limited to,			

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	"... Resident abuse must be reported immediately to the administrator. The facility Administrator will ensure a thorough investigation of alleged violations of individual rights and document appropriate action..." This State deficiency relates to Complaints IN00408817 and IN00408888.			
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 record review and interview, the facility failed to ensure physician's orders were obtained prior to a QMA administering a prescriptive medication to a resident for 1 of 7 resident's reviewed for health services. (Resident C) Findings include: The clinical record for Resident C was reviewed on 5/23/23 at 2:00 p.m. The diagnoses included, but were not limited to, hepatitis and lung cancer. The nurse's note, dated 5/11/23 at 2:35 p.m., indicated the resident came to the nurse's station indicating he needed help. When the nurse assessed him, he had tremors and spasms in his left arm and left leg. His vital signs were obtained and were within normal limits. Staff encouraged the resident to go to the hospital. The resident did not want to go. QMA (Qualified Medication Aide) 3 called for EMS (Emergency Medical Services) to	R 0241	R241 410 IAC 16.2-5-4(e)(1) Health Services The facility failed to ensure physician's orders were obtained prior to a QMA administering a prescriptive medication to a resident for 1 (Resident C) of 7 resident's reviewed for health services. **Corrective actions for resident that was affected by the alleged deficient practice:** Resident C was evaluated in ER and returned to facility with no harm from med error. MD was made aware of the medication being administered without an order. **Other residents having the**	06/21/2023

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	come and assess the resident. While awaiting EMS, the nurse gave the resident a banana and ice water and prepared paperwork for a potential hospital visit. As she was preparing paperwork, QMA 3 told the nurse he gave the resident KCL (potassium) which he did not have an order for. QMA 3 indicated to her, " ... it would get in his system faster ..." The nurse went to re-assess the resident and his vital signs were still within normal limits. EMS arrived and encouraged the resident to go to the hospital for evaluation. The resident left with EMS at 3:00 p.m. The clinical record lacked documentation of any physician's orders for potassium for Resident C. The hospital report, dated 5/11/23, indicated the resident presented to the emergency department with what the resident described as twitching in his left upper extremity. His potassium was elevated in the emergency department to 5.9 (normal value 3.5 to 5.1). He was likely volume depleted. He was given intravenous fluids. His diagnoses indicated hyperkalemia. During an interview on 5/24/23 at 9:16 a.m., LPN 4 indicated the potassium incident happened on 5/11/23. The resident came to the nurse's station and indicated he needed help. His left arm and left leg were spasming. She assessed him as QMA 3 called EMS. As she was getting the paperwork ready, that's when QMA 3 told her " ... I gave him some liquid potassium. I figured it would get in his system quicker..." By that time EMS was there and they encouraged him to go to the hospital. The resident did not have an order for liquid potassium. During an interview with the ADON on 5/23/24 at 9:41 a.m., she indicated she was made aware of the		**potential to be affected by the said deficient practice:** All residents who receive medications from clinical staff have the potential to be affected by the alleged deficiency. **Measures put into place to ensure that the alleged deficient practice does not occur:** QMA3 is no longer employed by the facility. LPN4 is no longer employed by the facility. On 5/31/2023, all nurses & QMAs were re-educated by DON & ADON on med-pass policy & the rights of medication administration. DON or designee will complete a medication administration skills check for each nurse & QMA. Newly hired nurses & QMAs will complete medication administration skills check during orientation. **How the corrective actions will be monitored to ensure the deficient practice will not recur:** Pharmacy will conduct medication administration in-servicing & audit med carts quarterly for all nurses & QMAs. Discrepancies will be immediately addressed & results of audit will be reviewed at QAPI to determine educational needs. DON or designee will conduct	

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	potassium incident on 5/11/23. She was not in the building that day, however both LPN 4 and QMA 3 had informed her they had sent the resident to the hospital. During her investigation, she spoke to the resident who had received the potassium and was sent to the hospital. The progress note indicated the potassium was given. He had to have an EKG (electrocardiogram) and intravenous fluids ran, because his potassium was elevated at 5.9. Later after they ran the fluids it was a 4.3. During an interview on 5/24/23 at 10:33 a.m., the DON indicated before she came back to work on 5/15/23, the ADON told her they had given the resident liquid potassium. The DON started auditing everything she could audit and educated the staff on their scope of practice. The resident did not have an order for potassium. She indicated, " ... QMA 3 decided to be a doctor that day ..." During an interview on 5/24/23 at 11:18 a.m., the DON indicated staff had to have an order for a medication before they gave anything. They had to make sure they had the right order, route, dose, person, time, the whole nine yards. During an interview on 5/24/23 at 11:45 a.m., the ED (Executive Director) indicated they asked the resident if he was given liquid potassium. The resident indicated he had received liquid potassium and QMA 3 administered it. During an interview on 5/24/23 at 12:29 p.m., the ADON indicated she interviewed Resident C and asked if he received liquid potassium. He indicated to her he did receive it. He was alert and oriented and did all his own medications. She absolutely believed it was a true statement.		medication administration skills checks quarterly for nurses & QMAs. Process will be monitored for completion by ED or designee & will be on-going. DON or designee will maintain medication administration learning records for all nurses & QMAs & ensure skills checks are completed upon hire & quarterly thereafter. . Process will be monitored for completion by ED or designee & will be on-going. DON or designee will compare medications against orders for one random resident three times a weekly. Results will be reviewed at QAPI & committee will determine stop date based upon compliance.	

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	The Medication Administration Policy, last revised 1/2017, provided on 5/24/23 at 12:06 p.m., included, but was not limited to, "... Policy... Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so... Medications are administered in accordance with written orders of the prescriber..." This State deficiency relates to Complaint IN00408817.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to ensure physician notification of a medication error for 1 of 7 residents reviewed for physician notification. (Resident C) Findings include: The clinical Record for Resident C was reviewed on 5/23/23 at 2:00 p.m. The diagnoses included but were not limited to lung cancer and hepatitis. The nurse's note, dated 5/11/23 at 2:35 p.m., indicated Resident C presented with muscle twitching and EMS (Emergency Medical Services) was notified. As LPN (Licensed Practical Nurse) 4 prepared the paperwork, QMA 3 told her he gave the resident KCL (potassium) which he did not have an order for. QMA 3 indicated to her, " ... it would get in his system faster ..." The nurse went	R 0247	R247 410 IAC 16.2-5-4 (e)(7) Health Services The facility failed to ensure physician notification of a medication error for Resident C. **Corrective actions for resident that was affected by the alleged deficient practice:** Physician was made aware of medication error & an incident report was completed. **Other residents having the potential to be affected by the alleged deficient practice:** All residents have the potential to be affected by the alleged deficient practice.	06/21/2023

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	to re-assess the resident and his vital signs were taken and still within normal limits. EMS arrived and encouraged the resident to go to the hospital for evaluation. The resident left with EMS at 3:00 p.m. The hospital report, dated 5/11/23, indicated the resident presented to the emergency department with what the resident described as twitching in his left upper extremity. His potassium was elevated in the emergency department to 5.9 (normal value 3.5-5.1). He was likely volume depleted. He was given intravenous fluids. His diagnoses indicated hyperkalemia. The clinical record lacked documentation of any notification to the physician of the resident receiving potassium without an order. During an interview on 5/24/23 at 9:16 a.m., LPN 4 indicated QMA 3 had informed her on 5/11/23 that he had administered liquid potassium to Resident C, which the resident did not have an order for. She did not notify the DON or ADON until they came back on Monday or Tuesday. They indicated on Thursday, not to bother them because they were in a class. She did not notify the resident's doctor of the medication being given. She would normally notify them immediately. During an interview with the ADON on 5/23/24 at 9:41 a.m., she indicated she was not made aware of the potassium incident until 5/16/23. She was not in the building that day. However, both QMA 3 and LPN 4 called to tell her they had sent the resident to the hospital. In either one of the conversations, she was not made aware of the potassium. The DON had also been in the facility on 5/11/23 and she never reported the potassium		**Measures put into place to ensure that the alleged deficient practice does not recur:** Nurses & QMAs were re-educated on significant change of condition, documentation, and notification. Nurses & QMAs were re-educated on medication errors. DON & ADON were re-educated on investigation guidelines for medication errors. **6/15/2023** **How the corrective actions will be monitored to ensure the deficient practice will not recur:** DON, or ADON will maintain a log of ALL occurrences and review weekly to validate that incident reporting policy was followed. Discrepancies will be immediately addressed. The process will be on-going and reviewed during QAPI to identify patterns, trends, and educational needs.	

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	to her. The notification should have been made. There were open lines of communication 24 hours a day. During her investigation, she spoke to the resident who had received the potassium and was sent to the hospital. The progress note indicated the potassium was given. He had to have an EKG (electrocardiogram) and intravenous fluids ran, because his potassium was elevated at 5.9. Later after they ran the fluids it was a 4.3. During an interview on 5/24/23 at 10:33 a.m., the DON indicated she was in the facility on 5/11/23. LPN 4 was in working in the facility. She did not talk to LPN 4 any time during the 11th. She had been made aware earlier in the day they were sending Resident C out and that was all she knew of it. Before she came back to work on 5/15/23, the ADON told her QMA 3 had given the resident liquid potassium. When she came back on 5/15/23 she started auditing everything she could audit and educated the staff one their scope of practice. This State deficiency relates to Complaint IN00408817.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure a resident's record contained accurately documented information for 1 of 7	R 0349	*R 349 410 IAC 16.2-5-8 1(a) (1-4) Clinical Records* The facility failed to ensure a	06/21/2023

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		A. BUILDING 00 B. WING	05/24/2023

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	residents reviewed for resident records. (Resident B) Findings include: During the resident interview, dated 5/16/23 at 3:00 p.m., conducted by the ED, the resident indicated he took only one dose of his Valium every 2 to 3 weeks and only at nighttime. It was very rare he took it during the day. He did take it during storms at night. It was always after 4:00 p.m., never in the morning. The last time he had taken it was a few weeks prior to the interview date. He had not taken his diazepam in the morning for the last month. The clinical record for Resident B was reviewed on 5/23/23 at 11:30 a.m. The diagnoses included, but were not limited to, major depressive disorder and multiple sclerosis. The physician's order, dated 3/14/22, indicated the resident received diazepam 10 mg (milligrams) every 6 hours as needed for anxiety. The resident's Controlled Drug Use Record sheet for Diazepam 10 mg indicated on the following date and times the ADON cosigned the resident's diazepam administration: -On 3/20/23 at 10:00 a.m., 3/23/23 at 9:00 a.m., 3/29/23 at 10:00 a.m., 3/30/23 at 9:00 a.m., 4/3/23 at 10:00 a.m., 4/6/23 at 6:30 a.m. and 2:00 p.m., 4/9/23 at 9:00 a.m., 4/26/23 at 9:30 a.m., 4/27/23 at 11:00 a.m., 4/29/23 at 1:30 p.m., and 5/10/23 at 10:00 a.m. a dose of the medication was signed out by QMA (Qualified Medication Aide) 3 with the ADON's (Assistant Director of Nursing) initials beside it. During an interview with the ADON on 5/23/24 at		resident's record contained accurately documented information for 1 resident. **Corrective actions for resident that was affected by the alleged deficient practice:** QMA3 is no longer employed at the facility. LPN4 is no longer employed at the facility. Resident was provided with an accurate narcotic inventory sign out sheet. **Other residents having the potential to be affected by the said deficient practice:** All residents who receive controlled substances from clinical staff have the potential to be affected by the alleged deficiency. **Measures put into place to ensure that the alleged deficient practice does not occur:** Residents receiving controlled substances from staff were interviewed by clinical leadership to validate that they received the controlled substances that were signed out on inventory sheets. (R349 EX1) Clinical staff re-educated on documentation & the process for documenting on the controlled substance inventory sheets. **How the corrective actions will**	

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	9:41 a.m., she indicated she was not made aware of the diazepam concern until 5/16/23, which was when she started her investigation. She had not ever signed out or co-signed the medication. She attested the initials were hers, but she believed he had used their initials and just wrote them on the sheet. She believed he forged their signatures. The resident's Controlled Drug Use Record sheet for Diazepam 10 mg indicated on the following date and times LPN 4 cosigned the resident's diazepam administration: -On 3/25/23 at 7:00 a.m., 4/1/23 at 12:00 p.m., 4/4/23 at 11:30 a.m., 4/8/23 at 10:00 a.m., 4/27/23 at 11:00 a.m., 5/1/23 at 10:00 a.m., 5/6/23 at 5:30 a.m. and 9:00 a.m., 5/7/23 at 8:00 a.m., and 5/11/23 at 6:00 a.m., a dose of the medication was signed out by QMA 3 with LPN (Licensed Practical Nurse) 4's initials beside it. The handwritten statement of LPN 4, dated 5/16/23, indicated on 4/12/23 the nurse noticed Resident B's Valium was signed out more frequently than the resident usually received them. Most of his Valium were signed out by QMA 3. Upon assessing the narcotic sheet, LPN 4 realized her initials were signed by someone else behind QMA 3. On eight of the instances where her initials were signed, she had not even worked on those days. She informed the DON of her findings. During an interview on 5/24/23 at 9:16 a.m., LPN 4 indicated on 4/13/23, she observed all the Valium being signed out abnormally and she told the DON and the ADON about it. She told them she saw her initials being signed out on eight days she wasn't in the facility. There were multiple days signed off in her name that she was not working in		**be monitored to ensure the deficient practice will not recur.** DON or designee will review narcotic binders 5 x's a week for 4 weeks to ensure daily count & inventory sheets are being signed and weekly thereafter. ED, DON, & designee will do weekly random interviews x's 4 weeks with 3 residents who are receiving controlled substances from clinical staff to ensure they are getting their medications, then weekly with 1 resident x's 4 weeks. Results of audits will be reviewed during QAPI, and committee will determine a stop date based upon compliance.	

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	the building. She reviewed at this time the Controlled Drug Use Record sheet and indicated the medication was signed out in her name on several dates and she was not there on most of those occasions where her initials were cosigned. She had never once been asked to sign for the resident's Valium. She had never co-signed on any administrations of Valium for the resident. Of the ten times her initials were signed on the sheet she attested she signed none. The Controlled Substance Policy, last revised 10/2022, provided on 5/24/23 at 12:06 p.m. by the DON, included, but was not limited to, "... Controlled Substance proof of use records in the form of a declining inventory record are to be maintained... the Following information will be recorded... Signature of person administering the dose..." The Medication Administration Policy, last revised 1/2017, provided on 5/24/23 at 12:06 p.m. by the DON, included, but was not limited to, "... Policy... The individual who administers the medication dose records the administration on the resident's MAR [Medication Administration Record] directly after the medication is given..." The Qualified Medication Aide Scope of Practice, provided on 5/24/23 at 12:06 p.m. by the DON, included but was not limited to, "... The QMA shall not document in a resident's clinical record any medication that was administered by another person or not administered at all... Administer previously ordered pre re nata (PRN) medication only if authorization is obtained from the facilities licensed nurse on duty or on call. If authorization is obtained the QMA must... ensure that the resident's record is cosigned by the licensed nurse who gave permission by the end of the			

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	nurse's shift, or if the nurse was on call, by the end of the nurse's next tour of duty..." This State deficiency relates to Complaints IN00408817 and IN00408888.			