| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155844 | A. BUILDING 00<br>B. WING | 10/11/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SYMPHONY OF CHESTERTON LLC | 2775 VILLAGE POINT<br>CHESTERTON, IN 46304 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey and included the Investigation of Nursing Home Complaints IN00411671, IN00414039, IN00417763, and IN00418635. This visit included a State Residential Licensure Survey.<br><br>Complaint IN00411671 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00414039 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00417763 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00418635 - No deficiencies related to the allegations are cited.<br><br>Survey dates: October 3, 4, 5, 6, 10, and 11, 2023<br><br>Facility number: 013688<br>Provider number: 155844<br>AIM number: 201352370<br><br>Census Bed Type:<br>SNF/NF: 13<br>SNF: 34<br>Residential: 22<br>Total: 69<br><br>Census Payor Type:<br>Medicare: 19<br>Medicaid: 11<br>Other: 17<br>Total: 47 | F 0000 | This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The facility respectfully requests paper compliance Thank you for your consideration,<br><br>Respectfully,<br><br>Kevin Mehay<br><br>Symphony of Chesterton<br><br>317-525-3537 | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Kevin Mehay | Administrator | 10/26/2023 |

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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| | These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed on 10/13/23. | | | |
| F 0694 SS=D Bldg. 00 | 483.25(h)<br>Parenteral/IV Fluids<br>§ 483.25(h) Parenteral Fluids.<br>Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.<br>Based on observation, record review, and interview, the facility failed to ensure the intravenous (IV) antibiotic run time infused according to the physician's order for 1 of 1 IV medications observed. (Resident 6)<br><br>Finding includes:<br><br>On 10/5/23 at 1:15 p.m., LPN 2 entered Resident 6's room to administer his intravenous (IV) antibiotic. The LPN gathered her supplies, donned a gown and gloves, and began to set up the IV pump for the medication administration. The IV pump displayed a warning to reset the machine. Four separate attempts were made to reset the machine. The LPN retrieved a Dial-A-Flo IV tubing set (manual flow regulator or IV flow regulator). The LPN connected the Dial-A-Flo IV tubing to Resident 6's PICC line (Peripherally Inserted Central Catheter). The LPN began to administer the IV medication via the PICC line, using the Dial-A-Flo tubing.<br><br>On 10/5/23 at 1:45 p.m., LPN 2 attempted to remove Resident 6's IV antibiotic. There was medication remaining in the IV bag so the LPN | F 0694 | **POC for F694 Parenteral/IV Fluids**<br>**What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?**<br>No harm came to Resident 6 related to alleged deficient practice.<br>NP, resident, and family were immediately made aware of infusing time. No new orders were received from NP.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to be affected by this alleged deficient practice.<br>A full house audit was completed on all residents receiving IV medication to ensure the infusing time is completed | 10/26/2023 |

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| | continued to let the medication infuse.<br><br>On 10/5/23 at 3:07 p.m., LPN 2 informed the Director of Nursing (DON), that the resident had IV antibiotic fluid remaining in the bag. The DON indicated she would notify the Nurse Practitioner to make her aware that the resident would not receive the full dose of the IV medication and to notify the family. LPN 2 went back to the resident's room and the medication had completely infused. The infusion time was 1 hour and 52 minutes via the Dial-A-Flo. The label on the IV bag indicated the medication was to infuse over 30 minutes.<br><br>The record for Resident 6 was reviewed on 10/5/23 at 1:45 p.m. Diagnoses included, but were not limited to, vascular disease, acute osteomyelitis (bone infection) right ankle and foot, acquired absence of other right toe, and diabetes mellitus.<br><br>A Physician's Order, dated 9/16/23, indicated the resident was to receive IV Pipericillin (an antibiotic) 3.375 milligrams (mg) per 100 milliliters (ml) over 30 minutes every 8 hours via his PICC line.<br><br>Interview with the DON on 10/5/23 at 3:20 p.m., indicated an IV pump was ordered for the resident. She also indicated they didn't like using the Dial-A-Flo tubing because it doesn't always give the resident the full amount of the IV medication.<br><br>3.1-47(a)(2) | | according to the physician's order.<br>**What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>Nursing staff educated on ensuring that infusion of Intravenous (IV) medication run times are completed according to the physician's order.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?**<br>DON/Designee will Audit 10 IV medication administrations on random residents/days/shifts to ensure that infusing time is completed according to the physician's order.<br>DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.<br><br>Date of compliance: 10-26-23 | |
| F 0759<br>SS=D<br>Bldg. 00 | 483.45(f)(1)<br>Free of Medication Error Rts 5 Prcnt or More<br>§483.45(f) Medication Errors.<br>The facility must ensure that its- | | | |

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| | §483.45(f)(1) Medication error rates are not 5 percent or greater;<br>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during medication pass. Two errors were observed during 31 opportunities for errors during medication administration. This resulted in a medication error rate of 6.45%. (Residents 5 and 6)<br><br>Findings include:<br><br>1. During observation of medication administration on 10/5/23 at 4:30 p.m., RN 1 handed Resident 5 a Ventolin HFA inhaler. The resident administered his own inhaler with no instructions from RN 1 on how to properly administer the medication. The resident quickly pushed down on the inhaler twice for two puffs and immediately capped the inhaler and handed it to the RN. The RN put the inhaler in the cart and locked it.<br><br>The record for Resident 5 was reviewed on 10/5/23 at 4:40 p.m.<br><br>The October 2023 Physician's Order Summary (POS) indicated the resident was to receive his Ventolin HFA Inhaler, 2 puffs, 4 times per day.<br><br>Interview with RN 1 on 10/5/23 at 4:45 p.m., indicated the resident initiated the puffs too quickly, and he did not wait in between puffs.<br><br>A current facility policy, titled "Specific Medication Administration Procedures: Oral Inhalation Administration", indicated, ... "press down on inhaler once to release medication as resident starts to breathe in slowly through the | F 0759 | **POC for F759 Free of Medication Error Rights 5 Percent or More**<br>**What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?**<br>No harm came to Resident 5 or Resident 6 related to alleged deficient practice.<br>Resident 5 was assessed to have no signs of symptoms of respiratory distress, wheezing and/or congestion.<br>Resident 6 picc line remains patent.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to be affected by this alleged deficient practice.<br>A full house audit was completed on all residents with inhalers to ensure the specific wait time between puffs is performed.<br>A full house audit was completed on all residents with IV access to ensure flushes are being completed according to orders.<br>**What measure will be put into place or what systemic changes you will make to ensure that the deficient** | 10/26/2023 |

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| | mouth over 3 to 5 seconds" . Do not spray more than one puff at a time"... "If another puff of the same or different medication is required, wait at least 1-2 minutes between, or per manufacturer specifications, then repeat procedures above..."<br><br>2. During observation of medication administration on 10/5/23 at 3:07 p.m., LPN 2 was observed preparing to remove Resident 6's intravenous (IV) antibiotic. The LPN donned a gown and gloves and entered the resident's room. She flushed the resident's PICC line (Peripherally Inserted Central Catheter) with normal saline after disconnecting the antibiotic. No heparin (prevents clotting) was used to flush the PICC line.<br><br>The record for Resident 6 was reviewed on 10/5/23 at 1:45 p.m. Diagnoses included, but were not limited to, vascular disease, acute osteomyelitis (bone infection) right ankle and foot, acquired absence of other right toe, and diabetes mellitus.<br><br>A Physician's Order, dated 9/16/23, indicated the resident's PICC line was to be flushed with 10 milliliters (ml) of normal saline before and after medications, and then flush with 5 ml of heparin.<br><br>Interview with LPN 2 on 10/5/23 at 3:39 p.m., indicated that she never used heparin to flush the PICC line and she didn't know that she was supposed to.<br><br>Interview with the Director of Nursing on 10/5/23 at 3:41 p.m., indicated they didn't use heparin, but she would call and clarify the order to flush with saline after medication administration.<br><br>3.1-48(c)(1) | | **practice does not recur?**<br>Nursing staff educated on giving proper instructions while residents are self-administering medications including but not limited to waiting proper period of time between puffs while using inhaled medications that require more than one puff.<br>Nursing staff educated on proper flushing of an IV access according to the type of IV device.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?**<br>DON/Designee will randomly check 5 medication passes per week that include inhalers to ensure proper instructions are giving while residents are self-administering medications including but not limited to waiting proper period of time between puffs while using inhaled medications that require more than one puff.<br>DON/Designee will randomly check 5 medication passes per week that include IV flushes to ensure that IV accesses are being flushed according to the type of IV device.<br>DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by | |

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| | | | Quality Assurance Committee that further monitoring is needed, audits will continue.<br><br>Date of compliance: 10-26-23 | |
| F 0761<br>SS=D<br>Bldg. 00 | 483.45(g)(h)(1)(2)<br>Label/Store Drugs and Biologicals<br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>Based on observation, record review, and interview, the facility failed to ensure medications were stored properly for 1 of 3 medication carts observed. (C hallway, Cart 2). | F 0761 | **POC for F761 Label/store Drugs and Biologicals**<br>**What corrective action(s) will be accomplished for those** | 10/26/2023 |

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| | Finding includes:<br><br>On 10/6/23 at 9:37 a.m., LPN 3 was observed at the medication cart preparing to pass medications from Cart 2 on the C hallway. The cart was found to have 12 loose pills, varying in size, shape, and color. The pills were found in the bottom 3 drawers of the medication cart. The LPN removed the pills from the cart and disposed of them in the sharps container.<br><br>Interview with LPN 3 on 10/6/23 at 9:37 a.m., indicated she always cleaned her med cart and she knew the loose pills should not have been in the cart.<br><br>Interview with the Director of Nursing on 10/6/23 at 10:03 a.m., indicated the loose pills should not have been in the cart.<br><br>A current facility policy, titled " Medication Storage in the Facility: Storage of Medications", indicated... "Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier..."<br><br>3.1-25(m) | | **resident(s) found to have been affected by the deficient practice?**<br>No residents were identified to have been effected.<br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?**<br>All residents have the potential to be affected by this alleged deficient practice.<br>A full house audit was completed on all medication carts to ensure all carts are free of loose medications and medications are stored properly, safely, and securely.<br>**What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?**<br>Nursing staff were educated on proper, safe, and secure storage of medications and keeping carts clean and free of loose, unlabeled pills.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?**<br>DON/Designee will perform an audit twice a week (different day/shift) on all medication carts to ensure medications are stored properly, safely, securely, and free | |

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| | | | of loose, unlabeled pills.<br>DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.<br><br>Date of compliance: 10-26-23 | |
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00411671, IN00414039, IN00417763, and IN00418635.<br><br>Complaint IN00411671 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00414039 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00417763 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00418635 - No deficiencies related to the allegations are cited.<br><br>Survey dates: October 3, 4, 5, 6, 10, and 11, 2023<br><br>Facility number: 013688<br><br>Residential Census: 22 | R 0000 | This plan of correction shall serve as this facilities' credible allegation of compliance Preparation, submission, and implementation of the plan of corrections does not constitute an admission of or agreement with the facts and conclusions set forth in this survey report Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. The facility respectfully requests paper compliance Thank you for your consideration,<br><br>Respectfully,<br><br>Kevin Mehay | |

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| | These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on 10/13/23. | | Symphony of Chesterton<br><br>317-525-3537 | |
| R 0036<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(k)(1-2)<br>Residents' Rights- Deficiency<br>(k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed:<br>(1) a significant decline in the resident ' s physical, mental, or psychosocial status; or<br>(2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.<br>Based on record review and interview, the facility failed to notify the resident's Physician of a fall with injury for 1 of 3 residents reviewed for falls. (Resident 5)<br><br>Finding includes:<br><br>The record for Resident 5 was reviewed on 10/10/23 at 12:00 p.m. Diagnoses included, but were not limited to, hypothyroidism and osteoporosis.<br><br>A Nurses' Note, dated 9/15/23 at 6:37 a.m., indicated at 4:50 a.m., the guest was observed laying on the floor next to the bed and was unable to state what happened. A nursing assessment was completed and a skin tear was observed to the right arm. The area was cleansed with normal saline, steri strips were applied and a dry dressing was used to cover the area. The Director of Nursing (DON) and Administrator were notified. | R 0036 | **POC for R036 Residents' Rights-Deficiency**<br>**What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?**<br>No harm came to Resident 5 related to alleged deficient practice.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br>All residents have the potential to be affected by this alleged deficient practice.<br>A full house audit was completed to ensure notification of Physician is being performed due | 10/26/2023 |

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| | There was no documentation the Physician was notified of the fall with injury.<br><br>Interview with the DON on 10/11/23 at 1:00 p.m., indicated the Physician was not notified of the resident's fall with injury.<br><br>The revised 1/2023 "Accident/Incident" policy, provided by the DON on 10/11/23 at 1:05 p.m., indicated designated staff should contact family and the doctor and document as changes occur in the guest's medical record. If no injuries or change in the resident status due to an accident or incident, no further documentation was required in the medical record. | | to injury resulting from a fall and/or change in condition.<br>**What measure will be put into place or what systemic changes you will make to ensure that the deficient practice do not reoccur?**<br>Nursing staff were educated on notifying the residents physician of any fall with injury and/or change in condition.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, ie., what quality assurance program will be put into place?**<br>AL Director/Designee will monitor all falls weekly to ensure that physicians are notified of any injury resulting from a fall and/or change in condition.<br>AL Director/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.<br><br>Date of Compliance: 10-26-23 | |
| R 0217<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as | | | |

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| | follows:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.<br>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. | | | |
| | Based on record review and interview, the facility failed to ensure the service plan was signed by the resident and they were revised and updated according to the resident's change in condition for 3 of 7 residents reviewed for service plans. (Residents 1, 4, and 6)<br><br>Findings include:<br><br>1. The record for Resident 1 was reviewed on 10/10/23 at 2:15 p.m. Diagnoses included, but were not limited to, depressive disorder, dementia with psychotic disturbance, psychotic disorder, and anxiety. | R 0217 | **POC for R217**<br>**Evaluation-Deficiency**<br>**What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?**<br>No harm came to Resident 1, Resident 4, or Resident 6 related to alleged deficient practice.<br>Resident 1 no longer resides in this facility.<br>**How will you identify other** | 10/26/2023 |

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| | A 8/11/23 Senior Living Evaluation indicated the resident was not always oriented to person, place and time and required assistance with orientation.<br><br>A Behavior Note, dated 9/12/23 at 1:06 p.m., indicated the resident had been having anxiety and getting obsessive over little things like pillow cases, phones, and other things in his room.<br><br>A Nurses' Note, dated 9/17/23 at 3:47 p.m., indicated the resident appeared anxious and was observed with heavy breathing. The resident was observed going into different resident rooms and had to be redirected. He was trying to call his family and was having anxiety about finding their phone numbers.<br><br>A Behavior Note, dated 9/21/23 at 2:01 p.m., indicated the guest was agitated and was asking the same question over and over again. He was observed wandering in the hall and trying to find his room.<br><br>A Behavior Note, dated 10/5/23 at 3:37 p.m., indicated the guest jumped out of his chair and ran after the QMA. After he had caught up with her, her threw her against the wall. He was trying to find his pilot book. At 4:44 p.m., the resident's daughter was at the facility. The guest was insistent she sit by him, when she stated no she would not, he got up and attempted to push her. The resident was redirected to his room, however, he continued to pace and curse.<br><br>The Service Plan, dated 8/11/23, had no documentation of the resident's physical behaviors towards his daughter and staff.<br><br>Interview with the Assisted Living Director on | | **residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br>All residents have the potential to be affected by this alleged deficient practice.<br>A full house audit was completed to ensure all service plans were signed by residents or their responsible party.<br>A full house audit was completed to ensure all behaviors were addressed in service plans.<br>**What measure will be put into place or what systemic changes you will make to ensure that the deficient practice do not reoccur?**<br>Nursing staff/AL Director were educated on updating service plans to address behaviors.<br>Nursing staff/AL Director educated on ensuring all services plans are signed by resident or their responsible party.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, ie., what quality assurance program will be put into place?**<br>AL Director/Designee will monitor all behaviors weekly and ensure they are addressed on service plans.<br>AL Director/Designee will monitor all new service plans weekly and ensure they are signed by resident or their | |

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| | 10/11/23 at 1:34 p.m., indicated the resident's anxiety and combative behaviors were not addressed on his Service Plan.<br><br>2. The record for Resident 4 was reviewed on 10/10/23 at 12:55 p.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety, and COPD (chronic obstructive pulmonary disease).<br><br>A Service Plan, dated 8/15/23 was completed, however, was not signed by the resident or her responsible party.<br><br>Interview with the Assisted Living Director on 10/11/23 at 1:34 p.m., indicated the Service Plan was not signed by the resident.<br><br>3. The closed record for Resident 6 was reviewed on 10/10/23 at 10:45 a.m. Diagnoses included, but were not limited to, anxiety, stroke, hemiplegia (muscle weakness on one side of the body), and major depressive disorder.<br><br>A Service Plan, dated 7/17/23 was completed, however, was not signed by the resident or her responsible party.<br><br>Interview with the Assisted Living Director on 10/11/23 at 1:34 p.m., indicated the Service Plan was not signed by the resident or her responsible party. | | responsible party.<br>AL Director/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.<br><br>Date of Compliance: 10-26-23 | |
| R 0295<br><br>Bldg. 00 | 410 IAC 16.2-5-6(a)<br>Pharmaceutical Services - Noncompliance<br>(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.<br>Based on observation, record review, and | R 0295 | **POC for R295-Pharmaceutical** | 10/26/2023 |

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| | interview, the facility failed to ensure medications were secured in resident rooms for those who self administered their own medications for 1 of 2 residents reviewed for self administration of medication. (Resident 8)<br><br>Finding includes:<br><br>Interview with Resident 8 on 10/10/23 at 11:13 a.m., indicated he self administered his own medications. He indicated his medications were in the drawer by the counter. At that time, the drawer was not locked, it easily opened, and all of his medications were observed inside in containers. The resident indicated he never locked his room or the drawer and pointed to the keys which where secured around the arm of his wheelchair.<br><br>On 10/11/23 at 8:03 a.m., the resident was observed sitting his wheelchair in the hallway outside of the main dining room. At that time, his room door was wide open and the drawer that housed his medications was unlocked.<br><br>The record for Resident 8 was reviewed on 10/10/23 at 3:40 p.m. Diagnoses included, but were not limited to, type 2 diabetes, COPD (chronic obstructive pulmonary disease), and high blood pressure.<br><br>A Self Administration of Medication Assessment, dated 9/5/23, indicated the resident was independent with daily decision making and was deemed to self administer his own medications. All the medications were to be kept in his room.<br><br>Interview with LPN 1 on 10/11/23 at 8:30 a.m., indicated the resident was to have all of his medications locked in the drawer inside his room. There was a special drawer with a lock on it for | | **Services-Noncompliance**<br>**What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?**<br>No harm came to Resident 8 or any other resident related to alleged deficient practice.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br>All residents have the potential to be affected by this alleged deficient practice.<br>A full house audit was completed to ensure that medications were secured in resident rooms for those who self-administered their own medications.<br>**What measure will be put into place or what systemic changes you will make to ensure that the deficient practice do not reoccur?**<br>Nursing staff/AL Director were educated on ensuring that all residents that self-administer their own medications ensure their medications are secure in their rooms.<br>**How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, ie., what quality assurance program will** | |

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| | residents who self administer their medication.<br><br>The current 4/2004, "Self Administration of Medications and Treatment" policy, provided by the Assisted Living Director on 10/11/23 at 1:34 p.m., indicated medications and treatments for self administration were to be kept in a locked drawer/box in the resident's room. | | **be put into place?**<br>AL Director/Designee will monitor 10 residents weekly (different day/shift) that self-administer their own medications to ensure their medications are secured in their rooms.<br>AL Director/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.<br><br>Date of Compliance: 10-26-23 | |
| R 0349<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(a)(1-4)<br>Clinical Records - Noncompliance<br>(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:<br>(1) Complete.<br>(2) Accurately documented.<br>(3) Readily accessible.<br>(4) Systematically organized.<br>Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to follow up assessment and documentation after a fall with injury or change in the resident, antibiotic use, as needed (PRN) medication administered only after non-pharmacological interventions were attempted, and orders were obtained to treat a | R 0349 | **POC for R349- Clinical Records-Noncompliance**<br>**What corrective action(s) will be accomplished for those resident(s) found to have been affected by the deficient practice?**<br>No harm came to Resident | 10/26/2023 |

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| | skin tear for 4 of 7 residents reviewed for clinical records. (Residents 1, 2, 4, and 5)<br><br>Findings include:<br><br>1. The record for Resident 1 was reviewed on 10/10/23 at 2:15 p.m. Diagnoses included, but were not limited to, depressive disorder, dementia with psychotic disturbance, psychotic disorder, and anxiety.<br><br>An 8/11/23 Senior Living Evaluation, indicated the resident was not always oriented to person, place and time and required assistance with orientation.<br><br>Physician's Orders, dated 8/29/23 and discontinued on 9/17/23, indicated Seroquel (an antipsychotic medication) 25 milligrams (mg) every 8 hours as needed for agitation.<br><br>Physician's Orders, dated 9/21/23, indicated Seroquel 25 mg every 8 hours as needed for agitation.<br><br>The 9/2023 and 10/2023 Medication Administration Record (MAR) indicated the as needed Seroquel was signed out as being administered on 9/4 at 12:21 p.m., 9/9 at 11:55 a.m., 10/6 at 11:14 a.m., and 10/10/23 at 2:50 p.m.<br><br>An eMAR Administration note, dated 9/4/23 at 12:21 p.m., indicated "Guest family came and he was upset about belt then it was the cabinet. Gave PRN medication. Guest went up front to visit with family. Will continue to monitor." (sic)<br><br>An eMAR Administration note, dated 9/9/23 at 11:55 a.m., indicated "resident complained of anxiety. administered per nurse." (sic) | | 1, Resident 2, Resident 4 or Resident 5 related to alleged deficient practice.<br>Resident 1 no longer resides in the facility.<br>Resident 2 was assessed, stop date obtain for antibiotic ointment.<br>Resident 4 no longer resides in Assistant Living.<br>Resident 5 no longer resides in the facility.<br><br>**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**<br>All residents have the potential to be affected by this alleged deficient practice.<br>A full house audit was completed to ensure nonpharmacological interventions are attempted first before administering prn pharmacological interventions.<br>A full house audit was completed to ensure follow-up assessments and documentation are completed for residents who have infections following administration of antibiotics.<br>A full house audit was completed to ensure follow-up assessments and documentation are completed following fall with injury or change in the resident condition.<br>A full house audit was | |

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| | An eMAR Administration note, dated 10/6/23 at 11:14 a.m., indicated the Seroquel 25 mg medication was administered for agitation.<br><br>An eMAR Administration note, dated 10/10/23 at 2:50 p.m., indicated "Medication gave when guest is roaming hall with coat on. Very agitated , breathing hard and going to SNF [Skilled Nursing Facility] unit. Will continue to monitor." (sic)<br><br>Interview with LPN 1 on 10/11/23 at 8:45 a.m., indicated before administering the as needed Seroquel this morning she did try to do other interventions, but the resident remained agitated, however, she did not document what she had done.<br><br>Interview with the Director of Nursing on 10/11/23 at 8:45 a.m., indicated nurses were to try non-pharmacological interventions first before administering the as needed Seroquel.<br><br>2. The record for Resident 2 was reviewed on 10/10/23 at 1:30 p.m. Diagnoses included, but were not limited to, atrial fibrillation, glaucoma, osteoarthritis, high blood pressure, and cardiac pacemaker.<br><br>Nurses' Notes, dated 9/18/23 at 9:28 a.m., indicated the guest's right eye was red with discharge. The hospice nurse contacted the doctor. Nursing would continue to monitor.<br><br>Physician's Orders, dated 9/18/23, indicated Neomycin-Bacitracin-Polymyxin external eye ointment, apply a thin ribbon to the right eye two times a day.<br><br>There was no further assessment or | | completed to ensure that orders are obtained and documented for first aide treatments.<br>**What measure will be put into place or what systemic changes you will make to ensure that the deficient practice do not reoccur?**<br>Nursing staff/AL Director were educated that non-pharmacological interventions should be attempted first before administering any prn pharmacological medications.<br>Nursing staff/AL Director were educated on ensuring that follow-up assessments and documentation are completed following administration of antibiotics, falls with injury and change in status of resident.<br>Nursing staff/AL Director were educated on ensuring orders are documented for first aide treatments.<br><br>**How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur, ie., what quality assurance program will be put into place?**<br>AL Director/Designee will randomly monitor 5 residents weekly that receive prn medication to ensure nonpharmacological interventions are attempted first before pharmacological interventions. | |

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| | documentation regarding the right eye redness or drainage in nursing progress notes.<br><br>Hospice Nurse visit notes, dated 10/2, 10/4, 10/6, and 10/9/23, indicated there was no documentation or an assessment of the right eye for redness or drainage.<br><br>Interview with the Director of Nursing on 10/11/23 at 8:45 a.m., indicated there was no other assessments completed by nursing staff of the right eye redness and discharge.<br><br>Interview with the LPN 1 on 10/11/23 at 8:45 a.m., indicated the Hospice Nurse visited the facility several times a week to change the resident's pressure ulcer bandages.<br><br>3. The record for Resident 4 was reviewed on 10/10/23 at 12:55 p.m. Diagnoses included, but were not limited to, major depressive disorder, anxiety, and COPD (chronic obstructive pulmonary disease).<br><br>A Fall Event, dated 7/28/23 at 1:13 p.m., indicated the resident got up, lost her balance, and fell to the floor in her room. The resident had complaints of pain to her toes on both feet, however, nothing was observed, as far as swelling, redness or warmth.<br><br>There was no documentation of fall follow up or an assessment after the fall.<br><br>Interview with the Director of Nursing on 10/11/23 at 1:02 p.m., indicated a follow up assessment and documentation was to be completed after a fall if there was an injury. There was no follow up documentation of the resident after the complaints of pain to her toes. | | AL Director/Designee will randomly monitor 10 residents weekly that are on antibiotics, change in status or fall with injury to ensure that follow-up reassessments and documentations are completed.<br>AL Director/Designee will monitor all first aide treatments that are rendered to ensure that orders are in place.<br>AL Director/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.<br><br>Date of Compliance: 10-26-23 | |

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| | 4. The record for Resident 5 was reviewed on 10/10/23 at 12:00 p.m. Diagnoses included, but were not limited to, hypothyroidism and osteoporosis.<br><br>The resident was discharged to the hospital on 9/26/23 and was currently not in the facility.<br><br>A Nurses' Note, dated 9/15/23 at 6:37 a.m., indicated at 4:50 a.m., the guest was observed laying on the floor next to the bed and was unable to state what happened. A nursing assessment was completed and a skin tear was observed to the right arm. The area was cleansed with normal saline, steri strips were applied and a dry dressing was used to cover the area. The Director of Nursing (DON) and Administrator were notified.<br><br>There was no follow up assessment or documentation after the resident's fall with injury.<br><br>There were no Physician's Orders for the steri strips for the treatment of the skin tear.<br><br>Nurses' Notes, dated 9/25/23 at 10:07 a.m., indicated the guest had a change in behavior. She was very tired and not socializing like she normally did. The resident's daughter was worried the resident was dehydrated, so the physician was notified and a message was left.<br><br>Nurses' Notes, dated 9/25/23 at 12:51 p.m., indicated the guest refused to get up for lunch and she was asked if she wanted to go to the Emergency Room (ER) and she refused that as well. The daughter was informed she had been trying to reach the doctor, however, she only able to leave messages. | | | |

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| | Nurses' Notes, dated 9/25/23 at 4:24 p.m., indicated the resident's son had arrived to transport the resident to the ER.<br><br>A Nurses' Note, dated 9/26/23 at 8:33 a.m., indicated the guest had gone to the ER last night and an antibiotic was ordered for symptoms of a urinary tract infection. The writer called and spoke to the physician's nurse regarding the resident's assessment.<br><br>There was no further documentation in the nursing progress notes regarding the resident's condition at the time she had been transferred out of the facility.<br><br>Interview with the Director of Nursing on 10/11/23 at 8:45 a.m., indicated the resident had gone to the ER with family on 9/25/23. The ER had given the family a scrip for an antibiotic to be filled for a urinary tract infection. Staff called the hospital ER and they could not give a reason on why the antibiotic medication was to be initiated. The family were informed and were upset the ER did nothing for their mother, so they decided to take the resident to another hospital ER to be evaluated on 9/26/23 and the resident was then admitted. There was no documentation of an assessment of the resident before she left with her family to go to the ER on 9/26/23. There was no Physician's Order for the steri strips.<br><br>Interview with the DON on 10/11/23 at 1:02 p.m., indicated a follow up assessment and documentation was to be completed after a fall if there was an injury. There was no follow up assessment of the resident after her fall.<br><br>The revised 1/2023 "Accident/Incident" policy, provided by the DON on 10/11/23 at 1:05 p.m., | | | |

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| | indicated designated staff should contact family and the doctor and document as changes occurred in the guest's medical record. If no injuries or change in the resident status due to an accident or incident, no further documentation was required in the medical record. | | | |