Erin Beiriger

PRINTED: 06/27/2023 FORM APPROVED OMB NO. 0938-039

06/23/2023

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/06/2023		
	PROVIDER OR SUPPLIER	L SISTED LIVING AND MEMORY CA	RE	1255 DI	ADDRESS, CITY, STATE, ZIP COD EMAREE ROAD IWOOD, IN 46143	<u> </u>	
(X4) ID	CLIMMADY	STATEMENT OF DEFICIENCIE	I	ID	, 		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
R 0000							
Bldg. 00	This visit was for the Investigation of Complaints IN000409992 and IN00409670.		R 0	000			
	Complaint IN00409 to the allegations ar	1992 - State deficiencies related e cited at R349.					
	Complaint IN00409 the allegations are c	0670 - No deficiencies related to ited					
	Survey date: June 6	, 2023					
	Facility number: 01	4079					
	Residential Census:	53					
	This State Residenti accordance with 410	ial Finding is cited in 0 IAC 16.2-5.					
	Quality review com	pleted June 8, 2023.					
R 0349	410 IAC 16.2-5-8. Clinical Records -						
Bldg. 00	(a) The facility must on each resident. maintained under employee of the fa	st maintain clinical records These records must be the supervision of an acility designated with that records must be as					
	(2) Accurately doc (3) Readily access (4) Systematically	sible.					
	Based on interview failed to ensure the entered into the clin	and record review, the facility accurate documentation was ical record for 1 of 3 residents on was not accurately	R 0	349	This Plan of Correction is submitted under regulations applicable to long term care providers. This Plan of Correction is not to be construed as an	ction	07/28/2023
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE				Е	TITLE		(X6) DATE

Any defiency statement 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 disclodays 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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Executive Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/06/2023			
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CA			STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD CARE GREENWOOD, IN 46143				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH		RECTION (X5) HOULD BE APPROPRIATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	documented. (Resident B) Finding includes: On 6/6/23 at 11:30 a.m., Resident B's clinical record was reviewed. The diagnoses included, but were not limited to, Parkinson's disease and anxiety.				admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/of execution of this Plan does not constitute agreement by the facility that the surveyor's finding	e ne or ot	
	The Physician's orders included, but were not limited to:				or conclusions are accurate, the findings constitute a	_	
					deficiency, or that the scope a	nd	
	Ativan (anti-anxiety medication) 0.5 mg				severity regarding any of the		
	(milligrams) by mouth every 6 hours as needed for anxiety, initiated 4/28/23. Clonazepam (anti-anxiety medication) 0.25 mg, two				deficiencies are correctly appl Submission of this Plan is	iea.	
					evidence of compliance.		
	times per day at 9:00 a.m. and 5:00 p.m., initiated			Plan of Correction: R349			
	on 6/2/23.				What corrective actions will be)	
					accomplished for those reside	nts	
		R (Medication Administration			found to have been affected b	y the	
		he clonazepam was			deficient practice?		
	administered on 6/2	2/23 a 5:00 p.m.			· A medication cart audit		
		N			was performed and determine		
		Narcotic Sign Out Sheet			resident was given the correct		
	indicated the medication was signed out on 6/2/23 at 5:00 p.m., but was not documented on the MAR. The Clonazepam 0.25 mg Narcotic Sign Out Sheet indicated the medication did not arrive in the facility until 6/3/23. The Ativan 0.5 mg administration on 6/2/23 at 5:00 p.m. was documented as clonazepam 0.25 mg on				medication (Ativan) and the		
					narcotic sign-out sheet was correct however, it was not sign	nod	
					off on the EMAR. The	gried	
					Clonazepam, though docume	nted	
					as given on the EMAR, was no		
					given as it was not delivered f		
					the pharmacy yet. The reside		
					EMAR was reviewed for the		
					medication administration from	n	
	6/2/23 at 5:00 p.m.		6/2/23 and a nurse note will be				
					entered to document this spec	cific	
	On 6/6/23 at 2:30 p.m., the Executive Director (ED) provided the facility's policy on Medication Management, revised 2/16/23, and indicated it				medication administration		
					accurately.		
					The QMA involved in th	is	
		ently in use by the facility. The document on the MAR			particular medication documentation error will be		
			1		retrained on medication		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SUR COMPLETE 06/06/202	ED
	PROVIDER OR SUPPLIER	SISTED LIVING AND MEMORY C	1255 D	ADDRESS, CITY, STATE, ZIP COD DEMAREE ROAD NWOOD, IN 46143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E ERIATE	(X5) OMPLETION DATE
	This State Resident Complaint IN00409	ial Finding relates to 1992.		administration and document for 2 medication passes obe by a LPN. The QMA will un a full medication pass monit by the Health & Wellness Di or designee to ensure profici in medication administration accuracy of documentation. EMAR compared with the nasign-out sheets. The QMA observed by the Health & Wellness Director or design time/week for 4 weeks to en proficiency with accurate medication administration and documentation. How the facility will identify or residents having the potention be affected by the same definition practice and what corrective will be taken? Current resident's EM will be compared to the narrosign-out binder and reviewe accuracy by the Health & Wellness Director or design a weekly basis for 4 weeks was random audits to occur ongo Any errors will be corrected immediately and necessary corrective action with staff was taken. What measures will be put it place or what systemic chart the facility will make to ensut that the deficient practice do recur? Current resident's EM will be compared to the narrosign-out binder and reviewed that the deficient practice do recur?	erved dergo ored rector iency and on the arcotic will be ee 1 sure and other al to icient action ARS cotic d for ee on with oing. iill be ato ages re ees not ARS cotic	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/06/2023			
NAME OF PROVIDER OR SUPPLIER DEMAREE CROSSING ASSISTED LIVING AND MEMORY CAI			STREET ADDRESS, CITY, STATE, ZIP COD 1255 DEMAREE ROAD ARE GREENWOOD, IN 46143				
	E CROSSING ASS SUMMARY S (EACH DEFICIEN		1255 D	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) accuracy by the Health & Wellness Director or designee a weekly basis for 4 weeks wirandom audits to occur ongoin The staff will turn in each narce sign-out sheet to the Health & Wellness Director for review against the EMAR to ensure accurate documentation. With each quarterly pharmacy audit the Health & Wellness Director designee will ensure accurate documentation of medication administration. How the corrective actions will monitored to ensure the defici practice will not recur, i.e. what quality assurance program will put into place? The Health & Wellness Director or designee will collaborate with the pharmacis establish a training program of Medication Administration and procedure for accurate documentation. The retraining program will be completed by 7/28/23. The Executive Director will collaborate with the Health Wellness Director or designee review results of medication and will assist in implementation.	(X5) COMPLETION DATE Son th ng. cotic I be ent at II be st to n d the g tor n & tot udits		
				of necessary changes. This review process will happen we for 4 weeks and then quarterly going forward. By what date the systemic changes will be complete? 7/28/23	-		

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