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	06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEMAREE CROSSING ASSISTED LIVING AND MEMORY CARE	1255 DEMAREE ROAD GREENWOOD, IN 46143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN000409992 and IN00409670. Complaint IN00409992 - State deficiencies related to the allegations are cited at R349. Complaint IN00409670 - No deficiencies related to the allegations are cited Survey date: June 6, 2023 Facility number: 014079 Residential Census: 53 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed June 8, 2023.	R 0000		
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 interview and record review, the facility failed to ensure the accurate documentation was entered into the clinical record for 1 of 3 residents reviewed. Medication was not accurately	R 0349	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	07/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erin Beiriger	Executive Director	06/23/2023

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	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. The Physician's orders included, but were not limited to: Ativan (anti-anxiety medication) 0.5 mg (milligrams) by mouth every 6 hours as needed for anxiety, initiated 4/28/23. Clonazepam (anti-anxiety medication) 0.25 mg, two times per day at 9:00 a.m. and 5:00 p.m., initiated on 6/2/23. The June 2023 MAR (Medication Administration Record) indicated the clonazepam was administered on 6/2/23 a 5:00 p.m. The Ativan 0.5 mg Narcotic Sign Out Sheet 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 6/2/23 at 5:00 p.m. 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 was the policy currently in use by the facility. The policy indicated: ...document on the MAR....		admission or agreement with the findings and conclusions in the Statement of Deficiencies. The preparation/ submission and/or execution of this Plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. Submission of this Plan is evidence of compliance. Plan of Correction: R349 What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? · A medication cart audit was performed and determined the resident was given the correct medication (Ativan) and the narcotic sign-out sheet was correct however, it was not signed off on the EMAR. The Clonazepam, though documented as given on the EMAR, was not given as it was not delivered from the pharmacy yet. The resident's EMAR was reviewed for the medication administration from 6/2/23 and a nurse note will be entered to document this specific medication administration accurately. · The QMA involved in this particular medication documentation error will be retrained on medication	

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	This State Residential Finding relates to Complaint IN00409992.		administration and documentation for 2 medication passes observed by a LPN. The QMA will undergo a full medication pass monitored by the Health & Wellness Director or designee to ensure proficiency in medication administration and accuracy of documentation on the EMAR compared with the narcotic sign-out sheets. The QMA will be observed by the Health & Wellness Director or designee 1 time/week for 4 weeks to ensure proficiency with accurate medication administration and documentation. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · Current resident's EMARs will be compared to the narcotic sign-out binder and reviewed for accuracy by the Health & Wellness Director or designee on a weekly basis for 4 weeks with random audits to occur ongoing. Any errors will be corrected immediately and necessary corrective action with staff will be taken. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? · Current resident's EMARs will be compared to the narcotic sign-out binder and reviewed for	

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			accuracy by the Health & Wellness Director or designee on a weekly basis for 4 weeks with random audits to occur ongoing. The staff will turn in each narcotic 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 or designee will ensure accurate documentation of medication administration. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? · The Health & Wellness Director or designee will collaborate with the pharmacist to establish a training program on Medication Administration and the 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 to review results of medication audits and will assist in implementation of necessary changes. This review process will happen weekly for 4 weeks and then quarterly going forward. By what date the systemic changes will be complete? 7/28/23	