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	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
FORT HARRISON ALF OPERATIONS	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

(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 IN00460270 and IN00459173. This visit was in conjunction with a Post Survey Revisit (PSR) to a State Residential Licensure Survey and the Investigation of Complaint IN00455674 completed on April 10, 2025. Complaint IN00460270 - State deficiencies related to the allegations are cited at R0297 and R0305. Complaint IN00459173 - State deficiencies related to the allegations are cited at R0297. Survey date: May 29, 30, and June 2, 2025 Facility number: 014109 Residential Census: 49 This State Residential Findings is cited in accordance with 410 IAC 16.2-5. Quality review completed on June 6, 2025.	R 0000		
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to administer a narcotic pain medication as ordered by the physician for 1 of 5 residents reviewed for medication administration (Resident B). Findings include: The clinical record for Resident B was reviewed	R 0297	**Facility failed to ensure injectable medication was administered by a Licensed Nurse.** All residents receiving injectable medications have the potential to be at risk. DON completed an injectable administration in-service with staff.	06/17/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dametria Marshall	Executive Director	06/17/2025

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	on 5/30/25 at 10:10 a.m. The diagnoses included, but were not limited to, hypertension and abdominal wound. A service plan, initiated on 12/13/23, indicated he received medications. The goal was for the resident to be supported to take all medications safely and as ordered. The interventions included, but were not limited to, for the resident to have a clear understanding of medication, purpose, dose, and take as prescribed. A physician's order, dated 4/30/24, indicated he was to receive oxycodone (narcotic pain medication) 5 milligrams (mg); four tablets by mouth every six hours for pain. On 5/29/25 at 2:30 p.m., the Executive Director provided an Incident Report submitted to the Indiana State Department of Health (ISDH), on 5/9/25, that indicated Resident B had received an incorrect dose of oxycodone on 5/6/25. Qualified Medication Aide (QMA) 2 had administered four tablets of oxycodone 20 mg. Resident B should have received four tablets of oxycodone 5 mg. The Nurse Practitioner was informed. Resident B had displayed no confusion or distress due to the medication error. The preventative measures taken were the Director of Nursing (DON) provided in-servicing for the nursing staff and observed each of the QMA's on staff conduct a medication administration. During an interview on 6/2/25 at 10:15 a.m., the DON indicated, the morning of 5/7/25, QMA 2 had called her to report that a wrong dose of oxycodone had been given to Resident B. QMA 2 had administered the last tablets of the oxycodone 5 mg from the supply on 5/7/25 at 12:00 a.m. There was a new supply of oxycodone 20 mg sent from		DON updated the non-insulin injectable administration list and schedule. DON will audit residents receiving non-insulin injectables weekly to ensure that only the Licensed Nurse will complete the task weekly for 4 weeks and thereafter. **Facility failed to administer a narcotic pain medication as ordered by the physician** All residents receiving medications have the potential to be at risk. DON completed medication administration in-service with clinical staff. DON/RCC will complete medication administration training with each QMA to ensure the each QMA understands the 6 Rights of Medication Administration. DON/RCC will audit the medication administration for errors weekly for 4 weeks, bi-weekly for 4 weeks, then monthly thereafter.	

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	the pharmacy on 5/6/25. QMA 2 had not noticed the pharmacy had sent 20 milligram tablets instead of 5 mg tablets. QMA 2 had called the DON as soon as she noticed the error. Resident B had been informed of the error in the dose. The Nurse Practitioner had been informed and instructed the facility to observe for changes in his level of cognition. There had been no adverse reaction noted. The DON indicated QMA 2 should have checked the dose prior to administering the medication. This citation is related to Complaints IN00459173 and IN00460270.			
R 0305 Bldg. 00	410 IAC 16.2-5-6(f)(1-3) Pharmaceutical Services - Noncompliance Based on interview and record review, the facility failed to ensure a medication was refilled timely for 1 of 5 residents reviewed for medication administration (Resident B). Findings include: The clinical record for Resident B was reviewed on 5/30/25 at 10:10 a.m. The diagnoses included, but were not limited to, hypertension and abdominal wound. A service plan, initiated 12/13/23, indicated he received medications. The goal was for the resident to be supported to take all medications safely and as ordered. The interventions included, but were not limited to, for the resident to have a clear understanding of medication, purpose, dose, and take as prescribed. A physician's order, dated 4/30/25, indicated he	R 0305	All residents receiving medications from a pharmacy have the potential to be at risk. DON/ED completed mediation follow-up from pharmacy in-service. DON/ED completed how to order medications from pharmacy in-service. DON/RCC will complete an audit to track medication refills and new orders to ensure that medications arrive at the community within three days. if medications are not at the community the community will request medications from the local pharmacy. Audit will be completed daily for four week, twice weekly for four weeks and thereafter.	06/17/2025

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	was to receive naloxegol oxalate (medication for narcotic related constipation) 25 milligrams (mg); one tablet by mouth one time daily. The May 2025 Medication Administration Record (MAR) indicated Resident B had not received his naloxegol on the following days: 5/9/25, 5/16/25, 5/17/25, 5/18/25, 5/20/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, and 5/29/25. An Order Administration note, dated 5/17/25 at 9:10 a.m., indicated the naloxegol oxalate 25 mg was not administered due to waiting on pharmacy. A coordinate with provider note, dated 5/19/25 at 12:24 p.m., indicated the medication reorder process had been explained to Resident B. The staff of the facility would notify the Primary Care Physician (PCP) of medications that needed to be refilled. The PCP would send a script to Resident B's pharmacy of choice to be processed and filled. Resident B would be responsible for picking up the medications at the pharmacy. An Order Administration note, dated 5/20/25 at 8:50 a.m., indicated Resident B's naloxegol oxalate 25 mg had been reordered. The Director of Nursing (DON) had been notified. An Order Administration note, dated 5/22/25 at 6:58 a.m., indicated the naloxegol oxalate 25 mg was unavailable. The DON and Medical Director (MD) had been notified. During an interview on 5/30/25 at 1:30 p.m., Resident B indicated he was having trouble getting his medications refilled. He had begun using a new pharmacy due to billing issues and the medications were not being refilled in a timely manner. He had spoken with the DON, and they			

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	had agreed on a system for the refills. His constipation medication had not been refilled. During an interview on 6/2/25 at 12:47 p.m., the DON indicated Resident B recently changed pharmacies. When Resident B needed a medication refilled, the Nurse Practitioner was informed and would send an electronic prescription to Resident B's pharmacy of choice. The DON was unsure why the naloxegol oxalate had not been refilled. To the DON's knowledge, the Nurse Practitioner had sent in an electronic script for the medications. The facility had not received a pre-authorization request for the medication from the pharmacy. The facility had offered to have the naloxegol filled at the facility's pharmacy, but Resident B did not want that due to past billing issues. On 6/2/25 at 1:15 p.m., the Business Office Manager provided the current Medication Reordering Policy that indicated "...Residents not using House Pharmacy... 1. Nurse administering a medication leaving resident with 3 days or less, should contact local pharmacy for refill. If medication is out of refills, the ordering physician should be contacted to request refill to be sent the pharmacy asap [sic]. 2. If medication is not received and residents miss dose, notify supervisor for further directions..." This citation is related to Complaint IN00460270.			