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	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN SENIOR LIVING	7960 SHADELAND AVENUE NORTH INDIANAPOLIS, IN 46250

(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 IN00410804 and IN00412599. Complaint IN00410804 - No deficiencies related to the allegations are cited. Complaint IN00412599 - No deficiencies related to the allegations are cited. Unrelated deficiency cited. Survey dates: July 12 and 13, 2023 Facility number: 013328 Residential Census: 56 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 18, 2023	R 0000		
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, interview and record review, the facility failed to ensure a medication was administered per the physician orders for 1 of 3 residents reviewed for medication	R 0297	The facility request's a desk review for citation R-0297 what corrective action(s) will be accomplished for those residents	07/31/2023

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

Jennifer Helfrich | Executive Director | 07/31/2023

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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	administration. (Resident C) Findings include: The clinical record for Resident C was reviewed on 7/13/23 at 10:55 a.m. The diagnoses included, but were not limited to, hypertension, chronic pain, muscle spasm, and osteoarthritis. A Brief Interview for Mental Status (BIMS) assessment, dated 7/6/23, indicated Resident C had moderate cognitive impairment. An interview conducted with Resident C, on 7/12/23 at 1:41 p.m., indicated over the weekend, from 7/8/23 to 7/9/23, she did not receive her tizanidine (muscle relaxant) due to nursing staff telling her it wasn't available in the evening time. When she requested it in the morning over the weekend, she did receive it. On 7/11/23, she asked why she received her tizanidine that morning but not the evening prior, on 7/10/23, and they could not tell her why. A service plan for medications, revised 7/8/22, indicated the following, "...Will be supported to take all medications safely and as ordered...May use PRN [as needed] pain medication as per MAR [medication administration record]...." A physician order, dated 7/6/23, was noted for tizanidine 2 milligrams, 3 tablets to equal 6 milligrams, every 8 hours as needed (PRN) for muscle spasm. The electronic medication administration record (EMAR) for July of 2023 indicated the PRN tizanidine was not signed off, as administered, in the evening hours on 7/9/23, 7/10/23, and 7/11/23.		found to have been affected by the deficient practice; Day of survey July 13 staff and ISDH surveyor were notified medication was in medication cart. Residents were assessed and charts were reviewed on adverse effect and none were noted from missing the administration. • how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All residents receiving medications from the identified QMAs had the potential to be affected. Medications were reviewed for all residents to identify any other residents for whom medication was present but not administered. A review of the last 30 days of medical records did not identify any adverse reactions that might also indicate missing medications. No other residents were identified. • what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff, including LPNs and	

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	A physician order, dated 7/12/23, was noted for tizanidine 6 milligrams three times daily for chronic pain. The EMAR for July of 2023 indicated the tizanidine due from 7:00 p.m. to 11:00 p.m. was not signed off as administered on 7/12/23. A progress note, dated 7/12/23 at 10:12 p.m., indicated the tizanidine 6 milligrams was not administered due to the medication unavailable in the cart. An interview conducted with Resident C, on 7/13/23 at 12:22 p.m., indicated she did not receive her tizanidine the evening of 7/12/23. An observation and interview was conducted with Qualified Medication Aide (QMA) 2, on 7/13/23 at 11:50 a.m., of the medication cart containing Resident C's medications. There was a roll that contained the scheduled medications that Resident C received. QMA 2 indicated she had a card that contained 2 milligrams of tizanidine, 3 tablets to equal 6 milligrams, with 6 pockets/administrations of the medication available for use. The card was located in a side drawer of the medication cart. QMA 2 believed that the previous staff may not have known it was in the side drawer for use. Resident C did make QMA 2 aware that she didn't receive her tizanidine the evening on 7/12/23. An interview conducted with the Director of Wellness, on 7/13/23 at 1:51 p.m., indicated the expectations are for nursing staff to administer medications as ordered. If the medication cannot be found, she would expect to see communication with the pharmacy to obtain such medication.		QMAs were in-service to follow facility policy and procedure for administration of medication pass: what is done if the medication is not located which includes call pharmacy, progress note, involving another staff member to find missing medication, reporting off on medication missing or not administered and checking medication bank when medication is identified as not present. • how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DON or Designee will audit the dashboard administration records in accordance with the plan of care for missing medication administration cycle fill against medication administration report. Daily x/ 10 days, Weekly x/4weeks, Monthly x/2months. DON will provide additional education or disciplinary action up to and including termination at the time of identification if additional missing medication administrations for which the QMA or LPN failed to follow the medication administration policy and procedure are identified.	