STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155678	A. BUILDING 00 B. WING	11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WATERFORD PLACE HEALTH CAMPUS	800 ST JOSEPH DR KOKOMO, IN 46901

(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
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaint IN00420389. This visit included the Investigation of Residential Complaint IN00420503. Complaint IN00420389-No deficiencies related to the allegations are cited. Complaint IN00420503-State deficiencies related to the allegations are cited at R241. Survey date: November 20, 2023 Facility number: 002667 Provider number: 155678 AIM number: 200300090 Census bed type: SNF: 27 SNF/NF: 44 Residential: 43 Total: 114 Census payor type: Medicare: 20 Medicaid: 35 Other: 16 Total: 71 Waterford Place Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00420389. Quality review was completed on November 29, 2023.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Bishir	Executive Director	12/11/2023

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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R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00420503. This visit included the Investigation of Nursing Home Complaint IN00420389. Complaint IN00420503-State deficiencies related to the allegations are cited at R241. Complaint IN00420389-No deficiencies related to the allegations are cited. Survey date: November 20, 2023 Facility number: 002667 Residential Census: 43 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-5. Quality review was completed on November 29, 2023.	R 0000		
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on interview and record review, the facility failed to ensure the Nurse Practitioner (NP) entered a medication order correctly and to ensure a Qualified Medication Aide (QMA) notified a	R 0241	1.1 Resident B was affected with no adverse effects. Physician notified of medication error and resident was monitored per	12/11/2023

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	licensed nurse regarding the medication order discrepancy to prevent a medication error for 1 of 3 residents reviewed for medication errors. (Resident B) Resident B was admitted to the hospital after receiving an incorrect dose of an anti-anxiety medication. Finding includes: A document, titled "Intake Information," dated 10/25/2023, indicated a concern was called into the Indiana Department of Health regarding Resident B having a dentist appointment and she was scheduled to receive sedation medication prior to the dentist appointment. When the family member arrived to pick the resident up for the dentist appointment, she was "slumped over" in her wheelchair and was "out of it." She was unable to go to the dentist appointment. She was placed in bed and later that evening she was found unconscious, on her face, on the floor. She was taken to the Emergency Room (ER) and treated for an overdose. The record for Resident B was reviewed on 11/20/23 at 12:15 p.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, and presence of left and right artificial knee joints. Physician's orders included, but were not limited to, the following orders: 07/07/2023, Xanax (an anti-anxiety medication) 0.5 mg (milligrams) (4 tablets). Give four tablets by mouth as a single dose. Note: needed for a dental procedure: light sedation required to complete procedure. Resident was on a waitlist, so appointment date and time were currently		policy. 2 All residents with PRN anticonvulsant medication have the potential to be affected. All employees qualified to pass medications were educated on the medication administration policy. A house wide audit has been completed on like residents receiving controlled anticonvulsant medications to ensure accuracy of EMAR with prescribed medication. 3 As a measure of ongoing compliance, DHS or designee to observe medication administration on 5 residents on varying shifts to ensure compliance 3 times weekly x 4 weeks, then 2 times weekly x 4 weeks, then weekly x 4 weeks, then monthly x 3 month or until 100% compliance is maintained. 4 As a quality measure, the ED or designee will review any findings and corrective actions at least quarterly and ongoing until campus achieves one hundred percent compliance in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted.	

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	pending. 07/14/2023, Xanax 0.5 mg. Give one time at 9:45 a.m., on 10/23/2023, for tooth extraction. 07/14/2023, Xanax 0.5 mg. Give one time at 10:15 a.m., on 10/23/2023, for tooth extraction and send remaining two (2) Xanax with son to dentist appointment. 07/14/2023, Xanax 0.5 mg. Give 0.5 mg, at 9:45 a.m., one-half hour before pickup, then another 0.5 mg Xanax at 10:15 a.m., when son picked the resident up for the appointment. 10/19/2023, Xanax 0.5 mg. Give one time, at 9:45 a.m., for dentist appointment on 10/23/2023. 10/19/2023, Xanax 0.5 mg. Give one time, at 10:15 a.m., for dentist appointment on 10/23/2023. The label on the Alprazolam (Xanax) 0.5 mg medication card, dated 8/1/23, indicated to give four tablets (2 mg) by mouth for one day. A document, titled "Controlled Drug Use Record," dated 8/1/23, indicated QMA 1 signed out all four Xanax 0.5 mg tablets, on 10/23/23 at 9:30 a.m. A document, titled "Safety Events--Trilogy-Medication Error Event," dated 10/23/23 at 12:45 p.m., indicated a medication error event occurred on 10/23/23. The description indicated it was a miscommunication. The type of error indicated incorrect label and incorrect time. A progress note, dated 10/23/23 at 1:09 p.m., indicated Resident B's Power of Attorney (POA) called to remind the staff to have her ready and to administer half of the Xanax, at 9:30 a.m., with her			

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	antibiotic and the other half later. LPN 3 went to the medication cart to clarify the Xanax order as she was speaking with the POA, when she learned QMA 1 had administered the Xanax tablets with the prescription order which read "Alprazolam 0.5 mg tab Give 4 tablets (2 mg) by mouth for one day." There was no direction change sticker on the medication card to indicate a change in medication order. The administration time in the matrix indicated to give between 4:00 a.m., and 10:00 a.m. There was a general order, which indicated to give Xanax 0.5 mg for tooth extraction appointment. There was another general order indicating to give Xanax 0.5 mg for tooth extraction and send remaining two Xanax with her family member. The NP was notified for clarification of the Xanax order. She suggested the family member cancel the dentist appointment due to the prescription needing to read "Alprazolam 0.5 admin [administer] 2 tabs [tablets] one hour before dental procure [sic] (9:30 a.m.) and send remaining 2 tablets with son to admin if needed and to return to facility if not used." A progress note, dated 10/23/23 at 10:26 p.m., indicated spoke with son, who indicated the resident was being kept in the hospital overnight due to still being sedated. A document, titled "Employee Corrective Action Form," dated 10/24/23, indicated QMA 1 did not follow the policy with medication administration by not checking a medication card with a resident's Electronic Medication Administration Record order. The type of corrective action was a verbal warning. A document, titled "Documents Review Report," dated 10/23/23 at 7:38 p.m., indicated Resident B was admitted to the Emergency Room by the			

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	Emergency Medical Services (EMS) after a "Xanax Overdose." After being given 4 Xanax tablets she was found face down at the facility and had difficulty regaining consciousness. She indicated she was having a hard time staying awake. She was on oxygen at 4 liters by nasal cannula. She had a difficult time answering questions due to sedation and was unable to follow commands. On 10/23/23 at 9:47 p.m., the ER diagnosis was Xanax overdose. During an interview, on 11/20/23 at 2:46 p.m., RN 4 indicated Resident B was supposed to go to a dental appointment for a tooth extraction. She was to receive Xanax 0.5 mg one tablet prior to her son picking her up for the dental appointment, one tablet when she was picked up for the dental appointment and a whole tablet was to be sent with her to the dental appointment in case the oral surgeon wanted to administer it to the resident. The medication card indicated to give four tablets at one time. The NP wrote the order to give the Xanax 0.5 mg one tablet prior to the appointment, one after she was picked up, then send a whole tablet with her, but she sent the script into the pharmacy indicating to give all four of the Xanax 0.5 mg tablets at once. QMA 1 did not clarify the Xanax order prior to administering the order and gave the Xanax to the resident based off the order on the Xanax medication card, not the EMAR. A current policy, titled "Preparation and General Guidelines," dated 01/17 and provided by the Executive Director (ED) on 11/20/23 at 11:30 a.m., indicated "...FIVE RIGHTS...right dose...right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the			

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	dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a. Check #1: Select the Medication-label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose-the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights when putting the medication away. 5) The medication administration record (MAR) is always employed during medication administration...Prior to administration of any medication, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label. If the label and MAR are different and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away, and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions...B. Administration...2) Medications are administered in accordance with written orders of the prescriber. 3) If a dose seems excessive e considering the resident's age and conditions, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the facility personnel calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification...This interaction with the			

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	pharmacy and/or prescriber and the resulting order clarification are documented in the medical record as appropriate...." This citation relates to Complaint IN00420503.			