| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 155200 | A. BUILDING 00<br>B. WING | 10/08/2024 |

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| UNIVERSITY NURSING CENTER | 1564 S UNIVERSITY BLVD<br>UPLAND, IN 46989 |

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| F 0000<br><br>Bldg. 00 | This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00443026, IN00444504, IN00444824, and IN00444827.<br><br>Complaint IN00443026 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00444504 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00444824 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00444827 - No deficiencies related to the allegations are cited.<br><br>Survey dates: October 2, 3, 4, 7, and 8, 2024<br><br>Facility number: 000107<br>Provider number: 155200<br>AIM number: 100290330<br><br>Census Bed Type:<br>SNF/NF: 66<br>Total: 66<br><br>Census Payor Type:<br>Medicare: 5<br>Medicaid: 52<br>Other: 9<br>Total: 66<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed October 18, 2024. | F 0000 | POC's entered. completed audits available upon request. We are requesting desk compliance at this time. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Rachel Bishir | Executive Director | 10/30/2024 |

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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| F 0684 SS=D Bldg. 00 | 483.25<br>Quality of Care<br><br>A. Based on interview and record review, the facility failed to administer medications according to physician order for 2 of 9 residents reviewed for medication administration. (Residents 19 and 51)<br><br>B. Based on interview and record review, the facility failed to obtain daily weights according to physician order for 1 of 3 residents reviewed for nutrition. (Resident 65)<br><br>Findings include:<br><br>A1. Resident 19's clinical record was reviewed on 10/4/24 at 7:20 a.m. Diagnoses included flaccid hemiplegia (decreased muscle tone) affecting left nondominant side, spastic hemiplegia (muscle tightness) affecting right dominant side, dysphagia (difficulty speaking) following cerebral infarction, aphasia (loss of ability to communicate) following cerebral infarction, and contracture of left hand.<br><br>Current medications included, depakote sprinkles (anticonvulsant) 125 milligram (mg) twice daily via gastric tube, Eliquis (anticoagulant) 2.5 mg twice daily via gastric tube, gabapentin (anticonvulsant and nerve pain) 100 mg twice daily, and hydrocodone- acetaminophen (pain) 7.5-325 mg every four hours via gastric tube.<br><br>A September 2024 Medication Administration Report (MAR) indicated she did not receive her dose of hydrocodone- acetaminophen 7.5-325 mg on 9/18/24 at 12:00 a.m., and 9/24/24 at 12:00 a.m.<br><br>A September 2024 narcotic count sheet indicated the medication was not removed for her 12:00 a.m. | F 0684 | **F 684 Quality of Care**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>Resident 51 required no prn administration r/t missed pain medication. Resident was seen by MD post missed medications with no pain or negative outcome.<br>Resident 19 required no prn administration r/t missed pain medication. Resident had completed pain assessment with no increased pain.<br>Resident 65 discharge home, doing well.<br>Education completed with the Nurse by the DNS r/t following Physician orders.<br>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.<br>All residents residing at the facility have the potential to be affected.<br>DNS completed an audit of all residents with daily weight orders and residents receiving scheduled narcotics for monitoring going forward.<br>All nursing staff in-serviced per DNS/Designee by 10/31/24 on Physician orders specific to | 10/31/2024 |

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| | dose on 9/18/24.<br><br>A2. Resident 51's clinical record was reviewed on 10/7/24 at 9:45 a.m. Diagnoses included Parkinson's disease, dementia, type 2 diabetes, chronic pain syndrome, and long-term use of anticoagulants.<br><br>Current medications included, but were not limited to, furosemide (antidiuretic) 40 mg once daily, hydrocodone-acetaminophen (pain) 7.5-325 mg every 6 hours, warfarin (anticoagulant) 3 mg on Monday, Wednesday, Friday, and Saturday, and warfarin 6 mg on Sunday, Tuesday and Thursday.<br><br>A September 2024 MAR indicated on 9/18/24 and 9/24/24 he did not receive his 12:00 a.m. doses of hydrocodone- acetaminophen 7.5-325 mg. On 9/24/24 and 9/26/24 he did not receive his 8:00 p.m. doses of Warfarin 6 mg.<br><br>A September 2024 narcotic count sheet indicated the medication was not signed out on 9/18/24 at 12:00 a.m. On 9/24/24 at 12:00 a.m., it showed the medication was signed out, but the electronic medical record did not show the medication was administered.<br><br>During an interview, on 10/7/25 at 10:35 a.m., RN 4 indicated the narcotic was to be removed from the mediation card. Staff then sign, along with the date and time the medication was removed on the narcotic count sheet. After administration of the medication, staff was to document in the electronic medical record (eMAR). In the eMAR, staff was to click that the medication was prepped, given, and completed before the medication would show it was administered. Since the medication had been signed out on the narcotic count, he assumed the medication had been administered to | | obtaining weights and administering pain medication as ordered, documenting administering in Narc log and Emar, documenting weights in Emar.<br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.<br>All nursing staff in-serviced per DNS/Designee by 10/31/24 on Physician orders specific to obtaining weights and administering pain medication as ordered, documenting administering in Narc log and Emar, documenting weights in Emar.<br>Residents with daily weights identified are indicated on the clinical board and reviewed daily via compliance report.<br>Emar compliance report reviewed daily by IDT to ensure no missed medication administration with follow up as indicated.<br>Narcotic logs will be reviewed daily by assigned IDT member.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place.<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director. | |

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| | the resident. But, he indicated it could have been a drug diversion.<br><br>During an interview, on 10/7/24 at 10:38 a.m., LPN 7 indicated there were three steps staff must complete before the medication shows it was administered. To document that a medication was given in the eMAR, staff clicked on the prep box, given box, and then the complete box. Once all three steps have been completed, the medication would show it had been administered. If the narcotic count matches the count sheet, it has theoretically been given. It could indicate a possible drug diversion since the eMAR doesn't show the medication was administered.<br><br>During an interview, on 10/7/24 at 11:35 a.m., the DON indicated scheduled medications that were not marked completed would disappear from the medications to be done list after an hour had elapsed. Staff could have amended the eMAR to show the medication had been administered. She was unable to go back to see if the medication had been marked as prepped but not signed off as administered. If the medication hadn't been signed out of the narcotic book, it indicated it hadn't been administered. Medical Records usually completed the monitoring process for narcotics, but the current staff member was new to the position.<br><br>A current facility policy was requested for administering mediations per physician orders but was not received prior to facility exit on 10/8/24.<br>B1. Resident 65's clinical record was reviewed on 10/3/24 at 4:06 p.m. Diagnoses included acute respiratory failure with hypoxia, acute on chronic diastolic congestive heart failure, and pulmonary embolism (blood clot in the lungs).<br><br>A current physician order, dated 9/5/24, indicated | | CQI tool identified as Physician Orders will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed.<br>10/31/2024. | |

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| | to obtain daily weights for congestive heart failure and notify the physician of a weight gain of three pounds in a day or five pounds in a week. The clinical record lacked daily weights, refusals, or clinical notes indicating why the weights were not obtained on the following dates: 9/7/24, 9/8/24, 9/13/24, 9/14/24, 9/15/24, and 9/16/24.<br><br>An admission Minimum Data Set (MDS) assessment, dated 9/11/24, indicated the resident had mild cognitive impairment. The resident required partial to substantial assistance with activities of daily living and mobility.<br><br>A care plan, dated 9/5/24, indicated the resident was at risk for ineffective tissue perfusion related to congestive heart failure and pulmonary embolism. Interventions included, nursing staff were required to monitor vital signs (9/5/24) and obtain daily weights (9/9/24).<br><br>The care plan lacked indication of resident non-compliance with daily weights.<br><br>During an interview on 10/4/24 at 6:00 a.m., the DON indicated she would review the resident's daily weights.<br><br>Evidence of missing daily weights was not provided.<br><br>During an interview on 10/4/24 at 1:10 p.m., RN 6 indicated she was familiar with Resident 65 and he was not known to refuse any daily weights. Daily weights were obtained first thing in the morning by the CNAs and reported to the nurse on the unit so they could be recorded and reviewed by the nurse. Weights were documented in the Medication Administration Record (MAR) /Treatment Administration Record (TAR). She | | | |

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| | was not aware of any other area in which daily weights were recorded. At times, CNAs did not obtain daily weights. The weights should have been obtained by the nurse if they were not obtained by the CNA, prior to the end of the shift when the daily weight task was due.<br><br>During an interview on 10/7/24 at 10:56 a.m., RN 4 indicated daily weights triggered as a task to be completed by the nurse and were documented in the MAR/TAR. He was unaware of any other place in which daily weights were charted. At times, the CNAs did not obtain the daily weights. When daily weights were not completed on his shift, the information was passed on in report to the next shift to obtain the daily weights. During review of the resident's MAR/TAR for September 2024, he indicated several days lacked daily weights. The daily weights should have been completed according to the physician order.<br><br>During an interview on 10/7/24 at 3:37 p.m., the DON indicated daily weights should have been obtained according to the Physician's order unless the resident refused. Daily weights were typically monitored by the Medical Records staff member, but this position was vacant until recently. The Unit Managers were also responsible for monitoring that daily weights were obtained. The facility's process for monitoring the completion of daily weights was ineffective.<br><br>A current facility policy, last revised 9/2024, titled "Resident Weight Monitoring," provided by the DON on 10/7/24 at 3:33 p.m., indicated the following: "POLICY... It is the policy of this facility to weigh residents no less than monthly or per physician orders...."<br><br>3.1-37(a) | | | |

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| F 0689 SS=D Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>Based on observation, interview, and record review, the facility failed to provide directed supervision and implement immediate, resident-centered interventions to prevent falls for a cognitively impaired resident for 1 of 3 residents reviewed for accidents. (Resident 14)<br><br>Finding includes:<br><br>On 10/2/24 at 4:01 p.m., Resident 14 was observed in the memory care unit hallway with a rollator walker (walker with wheels) and shoes on her feet. A staff member accompanied her as she ambulated towards her room. She had a laceration with sutures on her midline forehead near the hair line. The skin on the bridge of her nose was purple and her nostrils contained a dried, dark red substance. Her bilateral eyes had a circular purple discoloration underneath them.<br><br>During an interview on 10/3/24 at 10:32 a.m., Resident 14's representative indicated the resident had several falls because the resident "takes off without her walker." The facility recently notified her of injuries when the resident tripped and fell.<br><br>On 10/3/24 at 12:00 p.m., Resident 14 was observed in bed with her eyes closed. Her rollator walker was not within reach. The rollator walker in the room was across the room and in front of the closet along the wall, by her roommate's bed.<br><br>Resident 14's clinical record was reviewed on 10/4/24 at 12:12 p.m. Diagnoses included, vascular dementia, Alzheimer's disease, and anxiety disorder. | F 0689 | **F 689 Free of Accident Hazards/Supervision/Devices**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.<br>Residents 14 fall care plan and interventions have been reviewed by IDT and updated.<br><br>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;<br>All residents with repeat falls and cognitive impairment have the potential to be affected.<br>Audit per DNS to identify residents with repeat falls in the past 30 days and cognitive impairment to ensure plan of care appropriate for fall prevention.<br>DNS/Designee to review residents identified via audit to ensure adequate supervision/interventions in place to prevent falls.<br>All Staff in-service to be complete by 10/31/24 per DNS/Designee on Fall Prevention Program/Supervision/Immediate interventions to prevent falls.<br><br>What measures will be put into place or what systemic changes | 10/31/2024 |

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| | A current physician's order, dated 3/9/22, indicated the resident could be up with her walker for mobility.<br><br>Current physician medication orders included the following: hydrocodone-acetaminophen (narcotic pain medication) 5-325 milligrams (mg) tablet by mouth twice daily, amlodipine (blood pressure) 5 mg tablet by mouth once daily, Lexapro (depression/anxiety) 10 mg by mouth once daily, propranolol (blood pressure/heart rate) extended release 60 mg tablet by mouth once daily, and Eliquis (blood thinner) 5 mg tablet by mouth twice daily.<br><br>Review of a quarterly Minimum Data Set (MDS) assessment, dated 9/11/24, indicated the resident had severe cognitive impairment. Mobility devices were not used during the assessment period. She required substantial assistance from staff for footwear, lower body dressing, toileting, and bathing. The resident required partial assistance from staff for transfers and supervision for walking. The resident had 2 or more falls with injury (except major) during the assessment period.<br><br>A current care plan, initiated 4/29/21, indicated the resident required assistance with activities of daily living including bed mobility, transfers, and toileting related to osteoarthritis, muscle weakness, and abnormalities of gait and mobility. Interventions include, assist with ambulation as needed - walker for mobility on the unit (4/29/21) and may be up ad lib with a walker for mobility (8/16/23).<br><br>A current care plan, dated 4/29/21, indicated the resident was at risk for elopement per the Elopement Risk Assessment related to cognitive | | will be made to ensure that the deficient practice does not recur;<br>All Staff in-service to be complete by 10/31/24 per DNS/Designee on Fall Prevention Program/Supervision/Immediate interventions to prevent falls.<br>Nurse will notify Nurse Management at time of fall to assist with immediate fall interventions.<br>IDT will review all Fall Events daily in Clinical Meeting, determine root cause of fall and implement supervision/intervention to prevent reoccurrence. Resident plan of care will be updated.<br>John Hopkins fall assessment will be completed on all new admissions and readmissions, LTC residents will have assessment quarterly and with significant changes with IDT reviewing resident fall plan of care.<br>DNS/Designee will round daily to ensure fall interventions are in place.<br><br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director.<br>CQI tool identified as Fall | |

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| | impairment. Interventions included, provide one on one attention and conversation as needed (2/17/23).<br><br>A current care plan, initiated 5/6/22, indicated the resident exhibited severe cognitive impairment related to Alzheimer's disease and dementia. Interventions included, provide the resident with prompts and cues as needed (5/6/22).<br><br>A current care plan, initiated 4/29/21, indicated the resident was at risk for falls due to age, high fall risk drugs, an unsteady gait, altered awareness of immediate physical environment, lack of understanding of one's physical and cognitive limitations, and a high fall risk score of 21. Interventions included the following: keep personal items within reach (4/29/21), place non-skid strips to extend the length of the bed (9/28/22), offer to assist the resident to rest in between meals (4/29/24), offer to assist the resident out of the dining room and into the lounge after meals (5/28/24), obtain a therapy referral to screen for appropriate equipment for ambulation (6/3/24), staff to encourage the resident to use the walker during ambulation (8/8/24), obtain a therapy referral related to balance, for continued walker use/wheelchair (10/2/24), and continue to discourage the resident from entering other resident's rooms (10/2/24).<br><br>A Physician Progress Note, dated 10/3/24 at 1:44 p.m., indicated the resident had a fall a few days ago with facial injuries due to unsteadiness.<br><br>On 4/26/24 at 1:40 p.m., Resident 14 had an unwitnessed fall on the South end of the 200 Unit hallway in front of the exit doors. The resident indicated she walked into the exit doors with her walker and fell to the floor. The immediate | | Prevention will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>10/31/2024. | |

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| | intervention was to monitor her.<br><br>On 5/24/24 at 6:06 p.m., the resident had a witnessed fall and hit her head with no injury. The resident was walking in the dining room, tripped, and fell down. She hit her head on the refrigerator. An environmental factor was the hall tray cart in the dining room. No immediate new interventions were put into place.<br><br>On 6/2/24 at 6:00 p.m. , the resident had an unwitnessed fall without injury. The resident was at the counter in the kitchen lying on her back. The resident indicated she was looking at cookies on the counter and had planned to sit down on her walker. The walker was not locked and rolled out from under her. The immediate intervention was a therapy referral.<br><br>The resident had a recent therapy referral on 5/30/24, before this fall occurred.<br><br>On 8/6/24 at 4:00 p.m., the resident had a witnessed fall with no injury. The resident was in the television lounge and tripped on another resident's walker and fell to the floor. The immediate intervention was to remind the resident to use her walker and walk slowly.<br><br>On 9/2/24 at 3:15 p.m., the resident had a witnessed fall with no injuries in front of room 202. The CNA was redirecting the resident from entering room 202 when the resident lost her balance, hit her left shoulder on the door frame, and landed on her buttocks. The immediate intervention was a therapy referral.<br><br>The clinical record lacked and order for a therapy referral for this date. | | | |

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| | On 10/1/24 at 11:00 a.m., the resident had an unwitnessed fall with injuries that included a laceration to the forehead and a nasal fracture. The resident was exiting room 201 in the South end of the 200 unit hallway. As she turned while closing the door she lost her balance and fell to the floor. The immediate intervention was redirection when the resident wandered and encourage activities.<br><br>During a review of video surveillance footage, without volume, for 10/1/24 from 10:49 a.m. to 11:17 a.m., the following was observed: At 10:49 a.m., the resident walked out of her room, without her walker, on the North end of the memory care unit down towards the South end of the unit. She had a shirt in her left hand on a hanger and gave it to LPN 3, then turned around an ambulated back to her room past the Nurse's Station at 10:52 a.m. No staff assisted her back to her room so they could redirect her to use the walker. The resident ambulated back out of her room at 10:58 a.m., past LPN 3 at the medication cart, and without her walker. As she walked towards the South end of the unit, she met CNA 5 who continued walking towards the Nurse's Station. Neither LPN 3 nor CNA 5 attempted to assist the resident back to her room to get her walker. The resident continued on, past four administrative staff members who did not assist the resident to get her walker. She proceeded on to room 203 where she wandered into the room at 11:02 a.m. and remained in the room out of the surveillance camera view until 11:15 a.m. No staff entered the room and redirected her from wandering nor assisted her back to get her walker. Then the resident wandered out of room 203 and entered room 202. She remained in room 202 for 1 minute until she exited room 202 at 11:16 a.m. The resident walked across the hallway, without her walker, to room | | | |

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|---|---|---|---|
| | 155200 | A. BUILDING 00<br>B. WING | 10/08/2024 |

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| | 201. Hooks were on the door frame to hold a stop sign, but the stop sign was not in place. She attempted to open the door of room 201 at 1:17 p.m. when she lost her balance as she turned, and fell to the floor in the 200 Unit hallway resulting in injuries.<br><br>During an interview on 10/4/24 at 12:33 p.m., LPN 3 indicated Resident 14 was known to wander frequently and required frequent redirection from staff everyday. Staff also had to constantly remind her to use her walker because she self ambulated without her walker. On 10/1/24, LPN 3 was on the computer, near the dining room, when she heard a resident in room 201 yell "get out." She saw Resident 14 at the door of room 201, reached for the door knob, and the door slammed shut. At the same time, Resident 14 turned away from the door and lost her balance as she turned. She fell onto her left side. LPN 3 was uncertain if the door slammed as a result of her pulling the door shut with the door handle, or if the door was pushed shut from a resident inside the room. She fell out into the hallway on her left side and hit her face on the floor. The fall resulted in a broken nose and a laceration to her forehead. Resident 14 had her shoes on when she fell but did not have her walker with her. The resident did not have any staff with her or by her when she fell. She believed Resident 14 went to room 201 because she had resided in that room in the past.<br><br>During an observation on 10/7/24 at 12:57 p.m., the door was closed to room 201. Hooks were on the door frame used for placing a stop sign across the doorway, but the stop sign was not in place.<br><br>During an interview on 10/8/24 at 1:32 p.m., CNA 5 indicated Resident 14 was a high risk for falls and had a fallen recently on 10/1/24, during her shift. | | | |

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| | Interventions in place to prevent falls prior to her fall on 10/1/24 included the following: mesh stop signs across doorways, redirection with wandering into other residents' room, redirection for the resident to always use her walker, frequent reminders of her room location, offered snacks, be vigilant with monitoring, and ensure non-skid socks or shoes were on the resident's feet. The stop signs used across residents' doorways had been an effective method of redirection for Resident 14. On 10/1/24, CNA 5 saw Resident 14 headed towards the opposite end of the Unit from where she resided. She was unable to get to her before she fell due to providing assistance to another resident. When Resident 14 fell by the door of room 201, the mesh stop sign was not across the doorway and she did not have her walker with her. CNA 5 indicated she had been in room 201, prior to Resident 14's fall with injury, and failed to place the stop sign on the hooks when she exited the room. The resident had fallen due to her loss of balance when she turned after she started to enter room 201 without the use of her walker.<br><br>During an interview on 10/8/24 at 2:33 p.m., the DON indicated Resident 14 had frequent falls. She continued to have falls since her fall with injuries on 10/1/24.<br><br>During an interview on 10/8/24 at 3:13 p.m., the Administrator indicated Resident 14 ambulated without her walker, wandering into other residents' rooms throughout the review of the surveillance footage for 10/1/24 from 10:49 a.m. to 11:17 a.m. The staff had not redirected the resident from wandering into other residents' rooms. A stop sign was not in place across room 201's door when the resident started to enter the room before the resident fell on 10/1/24. The stop | | | |

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| | sign was ordered after the fall occurred on 10/1/24.<br><br>A current facility policy, revised 3/24, titled "Fall Management Policy," provided by the Administrator on 10/8/24 at 3:20 p.m., indicated the following: "Policy: It is the policy... to ensure residents residing within the community have adequate assistance to prevent injury related falls... Communities will implement resident-centered fall prevention plans for each resident at risk for falls or with a history of falls...."<br><br>3.1-45(a)(2) | | | |
| F 0755 SS=E Bldg. 00 | 483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records<br>Based on observation, interview, and record review, the facility failed to ensure reconciliation of controlled medications was completed for 2 of 3 medication carts reviewed. (200 Unit and 300 Unit medication carts).<br><br>Findings include:<br><br>Review of the 200 Unit "Shift Change Verification of Controlled Substances (12 hour)" log from 10/1/24 to 10/4/24 lacked the following information:<br><br>a. 10/1/24 Night shift- on-coming and ff-going shift signature and count completion<br>b. 10/1/24 Day shift - reconciliation of controlled medication count<br>c. 10/2/24 Night shift- reconciliation of controlled medication count<br>d. 10/2/24 Day shift - reconciliation of controlled medication count<br><br>During an observation at the time of interview, on | F 0755 | **F 755 Pharmacy Services/Procedures/Pharmacist Records**<br><br>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;<br>Reconciliation of controlled medications have been completed for 200 Unit and 300 Unit medication carts.<br>No residents were affected.<br>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;<br>All residents receiving controlled substance have the potential to be affected.<br>Audit of all controlled medications completed per DNS | 10/31/2024 |

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| | 10/4/24 at 6:38 a.m., LPN 3 indicated the night shift nurse on 10/1/24 had not signed the "Shift Change Verification of Controlled Substances" log on the 200 unit. She recalled who had been on duty when she took over on day shift and placed the night shift nurse's initials on the sheet for both blank spots. Four different shifts on the log for 10/1/24 and 10/2/24 lacked the count completion. Both the on-coming and off-going signatures as well as the count completion should have been on the log for each shift.<br><br>During an interview on 10/4/24 at 8:48 a.m., the DON indicated the shift to shift log was not signed for night shift on 10/1/24 because she believed they had signed on the wrong log. The "Shift Change Verification of Controlled Substances" log lacked documentation of count completion for each shift during shift change in October 2024. Both staff members that exchanged keys for a medication cart were required to complete the counts and the logs.<br><br>Review of the 300 Unit "Shift Change Verification of Controlled Substances (8 hour)" log from 10/1/24 to 10/7/24 lacked the following information:<br><br>a. 10/1/24 Night shift- on-coming and off-going shift signatures<br>b. 10/2/24 Night shift- on-coming and off-going shift signatures and reconciliation of controlled medication count<br>c. 10/4/24 Evening shift- reconciliation of controlled medication count<br>d. 10/5/24 Day shift- reconciliation of controlled medication count<br>e. 10/5/24 Evening shift - reconciliation of controlled medication count<br>f. 10/5/24 Night shift- reconciliation of controlled | | on all Units with reconciliation per pharmacy delivery verification.<br>All Nurses in-serviced per DNS/Designee by 10/31/2024 on Inventory of Controlled Substance Policy, and appropriately documenting on Shift Change Verification of Controlled Substance form.<br>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;<br>All Nurses in-serviced per DNS/Designee by 10/31/2024 on Inventory of Controlled Substance Policy, and appropriately documenting on Shift Change Verification of Controlled Substance form.<br>Assigned IDT will check the Shift Change Verification of Controlled Substance form for all units daily and report to DNS during clinical meeting.<br>DNS will add controlled substance verification to Clinical Agenda form to review daily.<br>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place;<br>Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held bi-monthly, and is overseen by the Executive Director.<br>CQI tool identified as | |

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| | medication count<br><br>A current facility policy, dated 2/1/18, titled "Inventory of Controlled Substances," provided by the DON on 10/7/24 at 3:33 p.m., indicated the following: "...Policy: It is the policy... to ensure that the incoming and outgoing nurses count all controlled substances at the change of each shift and document on the "Shift Change Verification of Controlled Substances" form...."<br><br>3.1-25(e)(2) | | Controlled Substance will be completed weekly x 4 weeks, monthly times 6 months, and quarterly thereafter until compliance is achieved.<br>If threshold of 100% is not met, an action plan will be developed to ensure compliance.<br><br>By what date the systemic changes will be completed;<br>10/31/2024. | |