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	06/20/2022

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

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00382485 and IN00381377. Complaint IN00382485 - Substantiated. State Residential Findings related to the allegations are cited at R0240 and R0270. Complaint IN00381377 - Unsubstantiated due to lack of evidence Survey dates: June 17 and 20, 2022 Facility number: 014109 Residential Census: 40 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 27, 2022	R 0000	ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, IN 46204 Re: June 20, 2022 Complaint Survey Plan of Correction Wickshire Fort Harrison 8025 Doubleday Drive Indianapolis, IN 46216 Dear Ms. Buroker: On June 20, 2022 a Complaint (IN00381377, IN00382485) Survey was conducted at the above referenced facility by the Division of Long Term Care. Please find the Statement of Deficiencies with our facility's Plan of Correction for the alleged deficiencies. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of July 15, 2022. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of	

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

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			deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Please feel free to call me with any questions. Respectfully submitted, Scott Deig Executive Director	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to honor medication time preferences and to administer medications, as ordered by the physician, timely for 3 of 4 residents reviewed for medication administration (Resident B, C, and E). Findings include: 1. The clinical record for Resident B was reviewed on 6/17/22 at 1:45 p.m. The Resident's diagnosis included, but was not limited to, end stage renal disease and diabetes. A Resident Evaluation and Level of Care, dated 3/23/22, indicated she was alert and needed no assistance communication. She required staff assists with administering medications. A physician's order, dated 5/11/22, indicated that she was to receive amlodipine besylate (blood pressure medication)5mg (milligram) two times daily.	R 0240	**1. Immediate Action Taken for those residents identified** Resident B's existing morning medication administration time changed on June 19, 2022 as requested to be no earlier than 8 am. Education with QMA's was completed by HWD on June 20, 2022. **2. How the facility identified other residents** Any resident residing in the facility had the potential to be affected. **3. Measure put into place/system changes** Audits were started weekly on July 11, 2022 for 4 weeks, then monthly for 3 months. **4. How the corrective actions will be monitored** The HWD or designee will be responsible for conducting the	06/20/2022

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	A physician's order, dated 5/11/22, indicated she was to receive Tradjenta (diabetic medication) 5 mg one time daily. A physician's order, dated 5/11/22, indicated she was to receive Protonix (stomach medication) delayed release tablets 20 mg one time daily. A Behavior Note, dated 6/6/22 at 5:02 a.m., indicated that she had refused her medications because they were not brought to her at the time, she preferred. During an interview on 6/17/22 at 2:05 p.m., QMA (Qualified Medication Aide) 2 indicated Resident B was alert and oriented. She received her medications in dose packs from the pharmacy. When receiving her medications, she preferred for the dose pack to be brought to her room and opened in front of her. She did not like her medications to be given to her in a medication cup. She wanted to see the dose pack before it was opened. She would refuse her medications if they were opened and put into a medication cup prior to her seeing the dose packet. During an interview on 6/20/22 at 9:11 a.m., Resident B indicated she had trouble getting her medications. The nursing staff had told her she was to get some of her medication at 6:00 a.m. She had never taken her medication that early before coming here. The QMA would come into her room at 5:00 a.m. or 5:30 a.m. and wake her up from her sleep to take the medication. They would hand her a cup of pills and when she asked what they were she was told by the QMA they were her medicines and she needed to take them. She did not like being woke up that early for medications and felt uncomfortable taking "loose pills in a cup" from someone she didn't know. She had a		audits and compliance. Any issues identified will be immediately addressed.	

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	meeting with the management of the facility and an agreement had been reached that the QMA's would bring her medication to her at around 7:30 a.m., but things had not gotten better. This had happened as recently as 6/19/22 at 5:00 a.m. The QMA's had told her that the computer "told them" to bring her medications at 6:00 a.m., so they had to do it that way. The June 2022 MAR (Medication Administration Record) indicated that her amlodipine besylate, Tradjenta, and Protonix were to be administered to her at 6:00 a.m. They had not been initialed as administered June 1 through June 3, June 6 through June 16. 2. The clinical record for Resident C was reviewed on 6/17/22 at 1:50 p.m. The Resident's diagnosis included, but was not limited to, diabetes and hypertension. A physician's order, dated 5/28/20, indicated he was to receive Januvia (diabetic medication) 100 mg tablet each day at bedtime. A physician's order, dated 2/16/22, indicated he was to receive Coreg (blood pressure medication) 3.125 mg tablet two times daily. A physician's order, dated 4/9/22, indicated he was to receive glimepiride (diabetic medication) 1 mg tablet each morning before breakfast. The June 2022 MAR did not contain initials indicating the Januvia had been administered on the following days: 6/2, 6/8, and 6/12/22. The June 2022 MAR did not contain initials indicating the Coreg had been administered on the following days: 6/2, 6/8, 6/9, and 6/12/22.			

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	The June 2022 MAR did not contain initials indicating the glimepiride had been administered on the following days: 6/1, 6/2, 6/3, 6/5, 6/7, 6/9, 6/12, 6/13, 6/14, 6/15, 6/16, and 6/17/22. 3. The clinical record for Resident E was reviewed on 6/17/22 at 2:30 p.m. The Resident's diagnosis included, but were not limited to, hypertension, chronic kidney disease, and benign prostatic hyperplasia (enlarged prostate). A service plan, dated 2/13/21, indicated he had no apparent memory problems. A Resident Evaluation and Level of Care, dated 12/21/21, indicated he was alert and oriented to person, place and time. A physician's order, dated 2/12/21, indicated he was to receive tamsulosin hcl (prostate medication) 0.4 mg tablet once daily at bedtime. A physician's order, dated 8/26/21, indicated he was to receive midodrine hcl (blood pressure medication) 10 mg tablet three times daily. During an interview on 6/17/22 at 1:25 p.m., Resident E indicated here were times he received his medication very late in the evenings. A couple of times he had missed evening doses of medications. This worried him because his physician had told him it was important for him to take his heart medications on time. The June 2022 MAR did not contain initials indicating his tamsulosin had been administered on 6/2/22 and 6/12/22. The June 2022 MAR did not contain initials			

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	indicating his midodrine had been administered at 9:00 p.m. on 6/2, 6/8, 6/9, and 6/12/22. During an interview on 6/20/22 at 11:55 a.m., the DON (Director of Nursing) indicated she was new to the facility but had been informed of the concern Resident B was having with receiving her medication and that Resident B should be receiving her medications as she preferred. All medications should be signed off on the Medication Administration Record when given. On 6/20/22 at 11:55 a.m., the DON provided the Pharmaceutical Services Policy, effective 11/01/2019, which read "... 9. Residents may use the pharmacy of their choice for medications administered by the community...11. The administration of medications and provision of residential nursing care will be as ordered by the resident's physician...c. The individual administering the medication will document the administration on the individual's medication and treatment record...name or initials of the person administering the drug or treatment..." This Residential tag relates to Complaint IN00382485.			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency (c) The facility must meet: (1) daily dietary requirements and requests, with consideration of food allergies; (2) reasonable religious, ethnic, and personal preferences; and (3) the temporary need for meals delivered to the resident ' s room. Based on interview and record review, the facility failed to honor a resident's food preference for 1	R 0270	**1. Immediate Action Taken for those residents identified**	06/22/2022

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	of 1 resident reviewed for food preferences (Resident B). Findings include: The clinical record for Resident B was reviewed on 6/17/22 at 1:45 p.m. The Resident's diagnosis included, but was not limited to, end stage renal disease and diabetes. A Resident Evaluation and Level of Care, dated 3/23/22, indicated she was alert and needed no assistance communication. During an interview on 6/20/22 at 9:11 a.m., Resident B indicated that she had concerns with her meals. She received a renal diet due to her being on dialysis. There were foods she shouldn't have and other foods she could have in moderation. She was aware of those foods, and at times would order some items which she knew were to be eaten in moderation. She was often told by the dietary staff that she could not have these foods. This was upsetting to her because she felt she was being treated as "a child". On Friday, 6/17/22, she had returned from dialysis and had been went to the dining room to retrieve her dinner. She was told by the dietary staff that it had already been placed in her room. The nursing staff had come to take her to her room. She sat down to eat her meal and found only 2 chicken breasts on her plate. She had ordered 1/2 of a taco salad along with the chicken breast. There was no other food on her dinner tray. She attempted to contact the kitchen, but all of the staff had left for the day. She was very upset that none of the kitchen staff informed her that she did not receive the taco salad and did not offer her any substitutes or other food items to go with her chicken breasts. She needed to have good		Education with staff was completed by DSD on 6/22/22. **2. How the facility identified other residents** Any resident residing in the facility had the potential to be affected. **3. Measure put into place/system changes** Audits were started weekly on July 11, 2022 for 4 weeks, then monthly for 3 months. **4. How the corrective actions will be monitored** The DSD or designee will be responsible for conducting the audits and compliance. Any issues identified will be immediately addressed.	

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	nutrition due to her dialysis. During an interview on 6/20/22 at 10:42 a.m., the Dietary Manager indicated that on Friday, 6/17/22, Resident B had only been served 2 chicken breasts for dinner. She had ordered a taco salad, but the cook did not send it due to it having tomatoes on it, which were restricted on her renal diet. Resident B should have received the taco salad. When residents were on a specialized diet they should be educated on the restriction, but not denied the things that are against their diet if they choose them. On 6/20/22 at 11:56 a.m., the Director of Nursing provided the Menus Policy, effective 11/1/19, which read "...It is the policy of ... to provide three nutritional meals per day consisting of a varied selection of items to choose from...10. Meals, beverages, snacks and desserts may not be withheld, unless in accordance with prescribed medical or dental procedures..." This Residential tag relates to Complaint IN00382485.			