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	08/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SENIOR LIVING PRESTWICK, LLC	182 S CR 550 E AVON, IN 46123

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: August 26 and 27, 2021. Facility number: 003902 Residential Census: 94 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on September 8, 2021.	R 0000	This plan of correction is submitted as required under state and federal law. The submission of this plan of correction does not constitute an admission on the part of Senior Living Prestwick, LLC D/B/A: Independence Village of Avon as to the accuracy of the surveyor's findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute a deficiency or that the scope or severity regarding the deficiency cited are correctly applied. Any changes to the community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidences and any corresponding state rules of civil procedure should be inadmissible in any proceeding on that basis. The community submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the community or any employee, agent, officer, director, attorney or shareholder of the community or affiliated companies.	
R 0116	410 IAC 16.2-5-1.4(a) Personnel - Noncompliance			

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

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Bldg. 00	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review, and interview, the facility failed to ensure employee records were kept on campus for inspection and review for 5 of 5 employees reviewed. Findings include: On 8/27/21 at 10:00 a.m., five random employee files were selected for review to ensure the hiring and annual in-service training requirements had been met. On 8/27/21 at 11:34 a.m., the Property Administrator provided the requested files. The files were reviewed with the Property Administrator at this time and found to lack documentation of all required records. The Property Administrator indicated the facility used a third-party Human Resource (HR) contract agency who facilitated the new-hire process. The facility, which had recently been purchased by a new company, used this third-party contract agency, and after an initial interview, the facility did not see or interact with that prospective employee again, until they started working at the facility. The HR contract agency took care of everything from the verification of nursing license, scheduling the TB (Tuberculosis skin tests), and the completion of a criminal background check. Because of the facilities recent transition to a new management company, they were still developing a process to implement the	R 0116	Plan of Correction for Survey Completed on 8/27/2021. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. The community will follow the specific procedures written and implemented for the screening of employees. Staff files will include required documentation and will be kept on campus for inspection and review. The Property Administrator was educated on the policy and state regulation for employee file compilation. The Executive Director and Property Administrator contacted the contracted Human Resource Agency to request the required documentation for each employee. 2. How will the facility identify	10/15/2021

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	new hire, general and job-specific orientation, as well as initial employee training for Residents' Rights, Dementia, and Abuse. The Property Administrator had a new-hire training binder but indicated it had not been put into practice yet. The employee file for Licensed Practical Nurse 17, hired on 6/13/17, lacked documentation of: a criminal background check, references, a TB skin test, a job description, general or specific job orientation, initial and annual in-service training for Resident Rights, Dementia and Abuse. The employee file for Certified Nursing Assistant 18, hired on 2/5/21, lacked documentation of: a criminal background check, references, the second step TB skin test, a job description, general or specific job orientation, initial and annual in-service training for Resident Rights, Dementia, and Abuse. The employee file for Dietary Aid 19, hired on 6/10/18, was empty and lacked documentation of all required records. The employee file for Cook 20, hired on 7/17/21, was empty and lacked documentation of all required records. The employee file for the Dementia Care Director, hired on 5/21/21, lacked documentation of a criminal background check, an annual TB test/screening, annual in-service training for Residents Rights, and Abuse. On 8/27/21 at 1:00 p.m., the Wellness Director provided a copy of current facility policy titled, "Employee Records File Order," dated 1/9/19. The policy indicated, " ...the purpose of the Employee Records policy is to establish a guideline for the		other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. The Executive Director and Property Administrator will ensure that all employees are screened properly and employee files are complete using State form 5440 for Employee Records as a tracking tool and files kept at the property for review. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? a. Employee files for all staff will be completed per policy and on campus for current staff by 10/15/2021. The policy will be followed immediately for each new employee. Additionally, employee records will be kept up-to-date using the State form 5440 as an additional measure of tracking. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? a. Random audits of 5 employee files will be done monthly by the Executive Director and Property Administrator to ensure success with employee screening and file compilation. 5. Plan of correction completion date: 10/15/2021	

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	acquisition and maintenance of employee information and records ... The community shall have a record for each person employed at the community. It is the responsibility of the Leader to gather required employee file items and forward to the Property Administrator for set up. It is the responsibility of the Property Manager to ensure that the employee files are set up completely and accurately ...Employee Records and file order to include but not limited to the following information: Application- name, address, telephone number, and references, Resume or summary of experience, education and training, professional Licenses, Background check results ...Medical: Physical, TB Test/chest X-Ray ... New Employee Training: ... Residents Rights, Dementia Care, [Abuse]...." 410 IAC 16.2-5-1.5(e)(1-4) Sanitation and Safety Standards - Deficiency (e) The facility shall maintain buildings, grounds, and equipment in a clean condition, in good repair, and free of hazards that may adversely affect the health and welfare of the residents or the public as follows: (1) Each facility shall establish and implement a written program for maintenance to ensure the continued upkeep of the facility. (2) The electrical system, including appliances, cords, switches, alternate power sources, fire alarm and detection systems, shall be maintained to guarantee safe functioning and compliance with state electrical codes. (3) All plumbing shall function properly and comply with state plumbing codes. (4) At least yearly, heating and ventilating systems shall be inspected. Based on observation, interview, and record review, the facility failed to ensure the Memory			
R 0148 Bldg. 00		R 0148	Plan of Correction for Survey completed on 8/27/2021.	12/31/2021

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	Care activity lounge was free from odors and stains, and furniture was in good repair, and the facility failed to ensure the individual apartment of a Resident was kept in good repair for 1 of 1 random room observations (Resident 71). Findings include: 1. During an initial, general tour of the Memory Care unit on 8/26/21 at 9:40 a.m., the following was observed: There were two, cloth-cushioned, arm-rest chairs in the Activity Lounge. An objectionable odor of urine was noted near the chairs, that wafted to the middle of the room, near the piano. In between the piano and one of the cloth-cushioned chairs, there was a brown stain on the wall that dripped to the floor, which caused a larger stain on the carpet. Two small flying insects were observed around the stain. There was a blue, cloth-cushioned love-seat. There were numerous stains on the cushion seats, as well as the arms rests of the love seat. During an interview on 8/26/21 at 9:44 a.m., Certified Nursing Assistant (CNA) 13 indicated, she smelled urine odor, and believed it came from one of the two cloth-cushioned chairs. Many of the residents were incontinent, and many of them liked to sit on those chairs, so they probably needed to be cleaned. She indicated she would let the Housekeeper know. During an interview on 8/26/21 at 9:50 a.m., Licensed Practical Nurse (LPN) 11, indicated, she smelled a urine odor too, it lingered on the furniture sometimes.		Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Housekeeping was immediately notified of the stained chairs and an upholstery cleaning and disinfection was immediately performed. Staff were reeducated the same day on cleaning procedures and how to notify Housekeeping for immediate needs. For Resident 71's apartment repair, Yardi (our maintenance tracking system) was checked and a work order was already in place for the repair. Resident 71 had recently flooded the apartment so, Maintenance was waiting for the baseboard to dry out completely before completing the repair. The repair was completed on 8/27/2021. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. Per policy, the staff were reeducated on the procedure for	

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	On 8/26/21 at 11:10 a.m., the above items were observed and reviewed with Executive Director (ED) 8. ED 8 indicated, furniture should be cleaned on an "as needed" basis. The love-seat stains needed to be cleaned. At this time, CNA 13 indicated, she and another CNA (CNA 12) did a "sniff-check" and agreed the chairs smelled like urine. They let the housekeeper know and she had come and sprayed the chairs. 2. During a random room observation on 8/26/21 at 10:34 a.m., Resident 71's room was observed with LPN 11. The baseboard at the entrance to his bathroom was missing and pieces of drywall and other debris was crumbled on the floor. The carpet was frayed and pulled away from the threshold between the bathroom tiles, and the hallway carpet. At this time, LPN 11 indicated it was in poor repair and she would see about getting it fixed. On 8/26/21 at 11:13 a.m., Resident 71's bathroom entrance was observed with ED 8, who indicated it was in disrepair and needed to be fixed. On 8/27/21 at 11:25 a.m., the Director of Nursing, (DON) provided a copy of current facility policy titled, "Housekeeping" dated 1/1/2017 and revised 6/1/2003. The policy indicated, "it is the intent of the Company to provide each resident with a clean and safe environment in which to live ... The Company will keep all walls, ceilings, floors or floor covers, and furnishings clean and in good repair. The community will be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards. There will be no chronic unpleasant odors...." On 8/27/21 at 11:25 a.m., the Director of Nursing,		reporting housekeeping and maintenance needs. We track maintenance needs via work orders through Yardi. We have also trained our Housekeeping staff to be an additional set of eyes in the apartment as they do weekly cleanings and report any repairs/needs/requests to be tracked in Yardi. Additionally, we have a preventative maintenance program that has our Maintenance team visit apartments at least annually to check for repairs, smoke alarm batteries, HVAC filters, perform warranty work, etc. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? a. A schedule for weekly furniture/upholstery cleanings in common areas and deep cleanings of common areas is in place. We have retrained staff on how to properly notify housekeeping and maintenance for immediate cleaning/disinfection needs and repair work that needs immediate attention. We have a daily facility walk checklist that is tracked and filed in-house. The staff have been retrained on this process. The Executive Director, Maintenance Director, Housekeeping Director, Property Administrator and Community Specialist will each be assigned a	

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	(DON) provided a copy of current facility policy titled, "Maintenance," dated 5/1/2017 and revised 6/1/2003. The policy indicated, " ...it is the job of all staff to identify areas of concern regarding the maintenance of the building. A routine preventative maintenance program shall be developed by the Executive Director and the Maintenance Director to include warranty requirements and usual standards applicable to the equipment...." On 8/27/21 at 11:25 a.m., the Director of Nursing, (DON) provided a copy of current, but undated facility policy titled, "Residents' Rights." The policy indicated, " ...Residents have the right to a dignified existence...."		day for the facility walk and will be assuring that all odors/stains, maintenance repairs and immediate housekeeping needs addressed immediately and tracked in Yardi. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? a. The Executive Director and/or Property Administrator will ensure that the daily facility walk is performed by doing weekly audits through 10/15/21; then monthly audits through 12/31/21. The Executive Director and/or Property Administrator will do audits of Yardi with the Maintenance Director to track maintenance repairs being done timely and will follow up on the repairs visually to ensure completion. The Executive Director and/or Property Administrator will visually inspect facility daily to ensure all areas are clean and odor free; ensuring all areas with issue are immediately addressed without delay. 5. Plan of correction completion date? 12/31/21	
R 0153 Bldg. 00	410 IAC 16.2-5-1.5(j) Sanitation and Safety Standards - Deficiency (j) The facility shall observe safety precautions when oxygen is stored or administered in the facility. Residents on oxygen shall be instructed in safety			

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	measures concerning storage and administration of oxygen. Based on observation, interview, and record review, the facility failed to ensure oxygen in use signs were outside resident's apartments for 4 of 5 residents reviewed for oxygen signs (Resident 3, 14, 16, and 50). Findings include: On 8/27/21 at 11:07 a.m., Resident 3's door was observed. There was no oxygen in use sign on the door, door frame, or shelf outside the resident's room. On 8/27/21 at 11:11 a.m., Resident 14's door was observed. There was no oxygen in use sign on the door, door frame, or shelf outside the resident's room. On 8/27/21 at 11:14 a.m., Resident 16's door was observed. There was no oxygen in use sign on the door, door frame, or shelf outside the resident's room. On 8/27/21 at 11:18 a.m., Resident 50's door was observed. There was no oxygen in use sign on the door, door frame, or shelf outside the resident's room. During an interview, on 8/27/21 at 1:29 p.m., the Wellness Director indicated residents who used oxygen should have had a sign on their door or door frame indicating, "Oxygen in Use." A current policy, titled, "Oxygen Therapy," dated 10/3/17, was provided by the Wellness Director, on 8/27/21 at 8:46 a.m. A review of the policy indicated, " ...A sign must be posted outside resident apartment indicating that oxygen is in	R 0153	Plan of Correction for Survey Completed on 8/27/2021. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. “Oxygen in Use” Signage was placed on 8/27/21 on the doors of affected residents and all apartments with oxygen in use were spot checked to ensure the appropriate signage is in place. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. All apartments with oxygen in use were spot checked to ensure the appropriate signage was in place. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? a. The Wellness Team will supply a list weekly of the apartments with oxygen in use.	08/27/2021

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	use."		Maintenance will ensure the correct signage is in place. Additionally, the Executive Director and/or Director of Nursing will follow up with weekly audits as a double check system to ensure the signage is in place where oxygen is in use. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? a. Weekly audits will be completed by the Executive Director and/or Director of Nursing to ensure the appropriate signs are in place. Any new residents will be added to the weekly tracking and “Oxygen in Use” signage will be placed immediately. 5. Plan of correction completion date? 8/27/21	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in			

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	writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure a resident's self-administration assessment was reviewed according to policy for 1 of 6 residents reviewed for medication self-administration (Resident 3). Findings include: During an interview, on 8/26/21 at 3:53 p.m., Resident 3 indicated she self-administered her own medications. Her medications were left beside her kitchen sink. Her alprazolam (controlled substance for anxiety) 0.5 mg was observed to be expired on 7/8/21. On 8/27/21 at 11:14 a.m., the Wellness Director indicated Resident 3 refused to give up her expired alprazolam until a new prescription arrived. The facility ordered another bottle for her. An assessment for Resident 3, titled, "Self-Administration of Medication Evaluation," dated 4/10/21, was provided by the Wellness Director, on 8/27/21 at 8:50 a.m. A review of the assessment indicated Resident 3 was approved to self-administer her own medications. During an interview, on 8/27/21 at 10:55 a.m., the Wellness Director indicated Resident 3's medication self-administration assessment was late. It should have been completed quarterly. A current policy, titled, "Medication Resident Self Administration," dated 8/1/17, was provided by the Wellness Director, on 8/26/21 at 11:00 a.m. A review of the policy, indicated, " ...The Wellness Director ...will review the Self-Administration of Medication Evaluation with the resident to evaluate their ability to safely administer and store	R 0216	Plan of Correction for Survey Completed on 8/27/2021. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Wellness Director/DON completed a self-medication review for affected resident #3 to determine ability to continue self-administering medication. Resident #3 was successful. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. Per policy, residents who self-medicate, will be assessed by the Wellness Director/DON on a quarterly basis or when a change of condition happens. All residents who self-administer medications will be reviewed quarterly and a schedule assessment reminder will be entered into Point Click Care. 3. What measures will be put into place or what systematic changes will be made to ensure	09/30/2021

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	their own medications. Reviews shall be performed ...quarterly."		that the deficient practice does not recur? a. All self-medication reviews will be charted, scheduled and tracked in Point Click Care. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? a. A monthly audit will be conducted by the Wellness Director/DON of 10% resident census to ensure self-medication reviews are done timely. Audits will be done once/month until 100% compliance has been reached then quarterly thereafter. 5. Plan of correction completion date? 9/30/21	
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 observation, interview, and record review, the facility failed to discontinue a medication, resulting in an overdose of a medication, and failed to provide a medication when the physician ordered it for 1 of 6 residents reviewed for medication administration (Resident 15). The facility failed to ensure the correct indication was listed for an antidepressant medication for a resident,(Resident 15), and failed to ensure an indication for an antipsychotic	R 0241	Plan of Correction for Survey Completed on 8/27/2021. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is	09/30/2021

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	medication was included on a current order for a resident with dementia (Resident 80) for 2 of 7 residents reviewed for medication orders. Findings include: 1. On 8/27/21 at 10:00 a.m., Resident 15's record was reviewed. Her diagnoses included, but were not limited to, age related cognitive decline, hyperlipidemia, insomnia, and depression. A physician's order, dated 6/2/20, indicated discontinue the previous Lexapro (antidepressant) orders and start an order for Lexapro 20 milligrams (mg), 1 tablet by mouth (PO) daily for 90 tablets. A pharmacy document, titled, "Consultant Pharmacist's Medication Regimen Review," dated 7/30/20, was provided by the Wellness Director. A review of the document indicated, Resident 15, "...has a new order for Lexapro 20 mg QD [every day] from 6/2/20. I did not see an order to discontinue her previous Lexapro 10 mg daily dose and it is still on her MAR. Please clarify if the Lexapro 20 mg was in addition to the 10 mg dose to make 30 mg QD [daily] of if the 10 mg dose should have been discontinued." A physician's order, dated 7/9/21, indicated, "For nursing to begin meds [medication] administration effective immediately." Resident 15's July 2021 MAR was reviewed. Multiple orders and discontinued orders remained on the MAR for escitalopram (Lexapro). a. Escitalopram 20 mg tablet, (date was not legible), Lexapro 20 mg tablet take one by mouth once daily at 8:00 a.m. for poor appetite. The nursing response on the MAR from 7/1/21 - 7/31/21 was blank. Nursing was to begin giving		required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Resident #15 order had previously been updated prior to 8/27/21 Survey. Physician's indications and diagnosis of resident #15 & # 80 have been requested for clarification and chart updated by Wellness Director/DON. Wellness Director/DON reviewed with staff. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. A review of all new physician's orders/changes will be entered into EMAR to be reviewed for completion of order that includes indication and diagnosis. Future orders will be clarified and updated in Point Click Care by the Wellness Director/DON and staff will be updated immediately. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? a. In service LPN's and QMA's with new orders/changes in medications will be performed by the Wellness Director/DON. Wellness Director/DON will review daily order/changes to ensure accuracy of medications resident	

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		A. BUILDING 00 B. WING	08/27/2021

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	Lexapro 20 mg, on 7/9/21, per physician's order. b. Escitalopram 10 mg tablet, (date was not legible), Lexapro 10 mg tablet take one by mouth once daily at 8:00 a.m. The nursing response on the MAR from 7/1/21 - 7/20/21 was X (not due). c. D/C - 7/20/21 4:17 PM, escitalopram 10 mg tablet, (date was not legible) Lexapro 10 mg tablet take one by mouth once daily at 8:00 a.m. The nursing response on the MAR from 7/1/21 to 7/20/21 was blank. On 7/21/21, it was listed as D/C. Resident 15's August 2021 MAR was reviewed. Multiple orders and discontinued orders remained on the MAR for escitalopram (Lexapro). Two nurses questioned the escitalopram in writing at the end of the MAR. a. D/C - 8/10/21 2:45 PM, escitalopram 20 mg tablet, (month did not print)/20/21, Lexapro 20 mg tablet take one by mouth once daily at 8:00 a.m. for poor appetite. The nursing response on the MAR from 8/1/21 to 8/3/21 was X (not due), from 8/4/21 to 8/6/21, zero (not administered) was indicated, and from 8/7/21 to 8/10/21, Lexapro 20 mg was given to Resident 15. b. D/C - 8/10/21 2:47 PM, escitalopram 10 mg tablet, (month did not print)/20/21, Lexapro 10 mg tablet take one by mouth once daily at 8:00 a.m. The nursing response on the MAR from 8/1/21 to 8/3/21 was X (not due), from 8/4/21 to 8/10/21, Lexapro 10 mg was given to Resident 15. c. D/C - 8/3/21 4:09 PM, escitalopram 10 mg tablet, (month did not print)/20/21, Lexapro 10 mg tablet take one by mouth once daily at 8:00 a.m. The nursing responses on the MAR from 8/1/21 to 8/3/21 was blank. On 8/4/21, it was listed as D/C. d. D/C - 8/3/21 4:15 PM, escitalopram 20 mg tablet, (month did not print)/20/21, Lexapro 20 mg tablet take one by mouth once daily at 8:00 a.m. The nursing response on the MAR from 8/1/21 to 8/3/21 was blank. On 8/4/21, it was listed as D/C.		to receive. Wellness Director/DON will conduct monthly recaps with wellness team of orders for each resident. Wellness Director/DON will conduct psychotropic medication reviews per facility policy. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? a. The Wellness Director/DON will conduct a monthly audit for 10% of census to include medication orders; transcription, completion of order, comparison of written orders received to EMAR entry. A monthly audit to include compliance of psychotropic medication review will be completed on a quarterly schedule. Monthly audits will be done until 100% compliance for 3 consecutive months; then quarterly thereafter. 5. Plan of correction completion date? 9/30/21	

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	e. On 8/4/21 at 8:00 a.m., Licensed Practical Nurse (LPN) 15 indicated, "Escitalopram 20 mg tablet, double meds. f. On 8/5/21 at 8:00 p.m., LPN 14 indicated, "escitalopram, needs clarification. A physician's document, dated 8/2/21, indicated, "Order clarification: D/C all previous Lexapro orders. Order Lexapro 20 mg 1 tablet PO daily. DX [diagnosis]: depression. During an interview, on 8/27/21 at 1:00 p.m., the Wellness Director indicated Resident 15 no longer self-administered her own medications as of 7/9/21. According to the physician's order on 6/2/20, Resident 15's Lexapro 10 mg should have been discontinued, and Lexapro 20 mg should have been started. The Lexapro 10 mg and Lexapro 20 mg should not have been given at the same time. Lexapro 20 mg should have been given by the nurses starting on 7/9/21 but was not started until 8/7/21. She indicated one part of the issue may have had to do with the facility changing pharmacies and there were too many conflicting orders on the MARs. The second part of the issue was the nurses not questioning the orders and reporting questionable orders to management. Her expectation was for the staff to report medication issues sooner, so management were able to resolve issues immediately. A document, titled, "Residency Agreement," dated 4/20211, was provided by the Wellness Director, on 8/26/21. It indicated, "The Community agrees to provide room, board, protection, supervision, assistance, and supervised personal care consistent with the resident service plan to ensure the health, safety, and well-being of the Resident."			

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	2. On 8/27/21 at 10:00 a.m., Resident 15's record was reviewed: Her diagnoses included, but were not limited to, age related cognitive decline, hyperlipidemia, insomnia, and depression. The Medication Administration Record (MAR) for June, July, and August, the Lexapro (antidepressant) 20 mg was listed as indicated for poor appetite. Documents, titled, "Consultant Pharmacist's Medication Regimen Review," were provided by the Wellness Director. One first document, dated 11/23/20, indicated, "Please clarify the indication for Lexapro. It currently has por [sic] appetite listed, which is not an indication for this medication." The second document, dated, 1/22/21, indicated the same, , "Please clarify the indication for Lexapro. It currently has poor appetite listed, which is not an indication for this medication."3. On 8/26/21 at 12:45 p.m., Resident 80 was observed during lunch. He picked up his glass of water and tried to take a sip, but his hands shook, and he splashed water in his face and spilled the cup. He became upset and cursed out loud repeatedly. He became agitated and attempted to stand up from his wheelchair. Certified Nursing Assistant (CNA) 12 calmly approached Resident 80 to help him sit back down in his wheelchair. Resident 80 became more upset, he grabbed CNA 12's lanyard which broke away, and he kicked at another unidentified CNA who came to help. His legs became tangled in the wheelchair pedals, and he almost fell, but CNA 12 steadied him as they both stumbled into the dining room table. CNA 12 assisted Resident 80 away from the wheelchair to go for a walk to calm down. Resident 80 remained aggressive as he jerked on her arm and cursed at her. CNA 12 assisted Resident 80 back to his room as she			

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	encouraged him to calm down and ensured him that everything was OK. When CNA 12 attempted to help him sit in his recliner chair, he grabbed her arm and punched her in the chest as he continued to yell and curse. Resident 80 let go, and CNA 12 was able to leave the room. During an interview on 8/26/21 at 12:50 p.m., CNA 12 indicated she and Resident 80 were good buddies, and sometimes he just had bad days. She held her arms out, and raised red areas were observed. She indicated she would probably be bruised tomorrow, but she did not mind because she knew Resident 80 could not help it. On 8/26/21 at 1:15 p.m., the Medical Record for Resident 80 was reviewed. He had current diagnoses which included but were not limited to: Lewy Body dementia with Parkinsonism (refers to symptoms of Parkinson disease such as slow movements and tremors that are caused by another condition). He had a current physician order for Seroquel (an antipsychotic medication) 12.5 mg (milligrams) with instructions to be given twice daily. There was no indication for this scheduled medication. He had a second current physician order for Seroquel, 25 mg, to be given as needed for, "agitation." On 8/27/21 at 10:10 a.m., the Wellness Director reviewed Resident 80's current physician orders and indicated, there should be an indication for all scheduled and PRN (as needed), especially an antipsychotic medication in a resident with serious behaviors. On 8/27/21 at 1:00 p.m., the Wellness Director			

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	provided a copy of current facility policy titled, "Psychotic Medication Review," dated 7/2018. The policy indicated, "The purpose of the Psychotropic Medication Review policy is to ensure psychotropic medications are used according to prescriber's guidelines at the lowest most effective dose for the purpose of resident safety ...Psychotropic medications may be used in the treatment of a variety of psychotic and anxiety disorders ... When a psychotropic medication is prescribed, a Psychotropic Medication Review form should be completed. Psychotropic medication review is to include benzodiazepines and antipsychotic medications. The review is to be completed by the Wellness Director...."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observtion, interview, and record review, the facility failed to ensure residents who self-administered medication kept their medications locked up for 6 of 7 residents reviewed for secured medications (Resident 3, 5, 6, 8, 9, and 16), and failed to ensure the physician was aware of all medications and all medications were in the residents medical record for 1 of 7 (Resident 6). Findings include: 1. During an interview, on 8/26/21 at 3:53 p.m., Resident 3 indicated she self-administered her own medications and did not lock her door when she left her apartment. Her medications were left beside her kitchen sink. Her alprazolam (controlled substance for anxiety) 0.5 mg was observed to be	R 0295	Plan of Correction for Survey Completed on 8/27/2021. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the true facts alleged or conclusion set forth in the statement of deficiencies. This Plan of Correction is prepared and executed because it is required by Federal State Laws. 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. Locked Medication Boxes are on order for all residents who self-administer medications. The	09/30/2021

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	expired on 7/8/21. On 8/27/21 at 11:14 a.m., the Wellness Director indicated Resident 3 refused to give up her expired alprazolam until a new prescription arrived. The facility ordered another bottle for her. 2. During an interview, with Resident 5 and Resident 6, they indicated they both self-administered their medications. Resident 5 indicated he had two medications he kept in the kitchen cabinet. Resident 6 indicated she had 5 medications she kept on the kitchen counter. They both indicated they did not lock their apartment when they left. Resident 6 indicated she had recently added vitmain D3 and iron to her medications. During an interview, on 8/27/21 at 11:20 a.m., the Wellness Director indicated when residents add new medications, they should let the facility know. The physician needed to know to decide about possible adverse drug reactions or side effects. 3. On 8/27/21 at 11:09 a.m., Resident 8's door was unlocked and fell open when knocked upon. During an interview, on 8/27/21 at 11:24 a.m., Resident 8 indicated his medications were in his room. He did not lock his door when he left his apartment. 4. On 8/27/21 at 11:05 a.m., Resident 9's door was observed propped open with no one inside. During an interview, on 8/27/21 at 11:22 a.m., Resident 9 indicated her medications were in her room. She did not lock her door when she left her apartment.		residents will be assessed by the Director of Nursing for the ability to self-administer medications and when approved will be trained on how to use the locked medication boxes. Residents have been retrained on the importance of locking their apartment at all times to secure self-administered medications. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice and what corrective actions will be taken? a. Per policy, residents will be assessed on their ability to self-administer medications and trained on the use of the locked medication boxes. Random audits will be performed on usage of secure medication lock boxes and assessments will be made to ensure medications are properly taken and secured. 3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? a. The Director of Nursing will ensure the assessment, training, proper medication training and storage of each resident per policy. 4. How does the facility plan to monitor its performance to make sure that solutions are sustained? a. Medication assessments	

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	5. During an interview, on 8/27/21 at 11:26 a.m., Resident 16 indicated her medications were in her room. She did not lock her door when she left her apartment. On 8/26/21 at 4:12 p.m., the Wellness Director indicated residents were evaluated before they could self administer their medications. All resident medications should be locked up at all times. She preferred them to lock them all in one place, in case they forgot to lock their apartment doors. A current policy, titled, "Medication Resident Self Administration," dated 8/1/17, was provided by the Wellness Director, on 8/26/21 at 11:00 a.m. A review of the policy, indicated, " ...The purpose of the Resident Medication Self Administration policy is to ensure residents that choose to self-administer their medication can do so safely ...all medications must be in the medical record...These medications must be stored in the resident's room in a secure manner...."		will be tracked through charting on Point Click Care. 5. Plan of correction completion date? 9/30/21	