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	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HELLENIC SENIOR LIVING OF ELKHART	2528 BYPASS ROAD ELKHART, IN 46514

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00423494 and IN00424063. Complaint IN00423494 - No deficiencies related to the allegations are cited. Complaint IN00424063 - No deficiencies related to the allegations are cited. Survey dates: January 2, 3, & 4, 2024 Facility number: 014241 Residential Census: 117 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/10/24.	R 0000	no deficiencies	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure authorizations for as needed (PRN) medications administered by a Qualified Medication Aide (QMA) were documented in the	R 0246	**R 246** **Interventions:** mandatory in-service was conducted on 01/18/2024 for all	01/31/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christina	Perry	01/30/2024

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	medical record for 1 of 7 residents reviewed for PRN medications. (Resident H) Finding includes: The record for Resident H was reviewed on 1/3/2024 at 9:15 A.M. Diagnoses included, but were not limited to: dementia with behavioral disturbance and major depressive disorder. A Physician Order, dated 7/2023, indicated Ondansetron tab 4 mg (milligram) take one tablet by mouth every 8 hours as needed for nausea or vomiting. A Medication Administration Record, dated November 2023, indicated Resident H had received Ondansetron 4 mg on 11/6/2023 at 2:48 P.M., which was signed by QMA 5. During an interview on 1/4/2023 at 9:30 A.M., the Administrator indicated the as needed Ondansetron was administered by a QMA. The QMA should notify the nurse for authorization and then document in the progress notes the following: "Nurse notified and permission given to administer the medication." A Progress Note, dated 11/6/2023 at 3:01 P.M., indicated "Resident stated she's been nauseous and had vomited. Resident stated she does not have any pain. Nurse notified." On 1/4/2023 at 9:45 A.M., the Administrator provided a policy titled, "MED 6- Medication Administration," dated 9/30/2022 and indicated the policy is the one currently used by the facility: "...34. If an alert and oriented resident request a medication ordered "PRN, or a resident with a dementia-related diagnosis shows symptoms of		employed QMAs regarding obtaining authorization from the nurse/DON/ADON prior to administering a PRN medication. The community DON/ADON or designated licensed nurse will monitor all PRN medications administered utilizing the EMAR and PointClick Care report system daily for 1 month then once weekly for 6 months ensuring proper authorization was received from a nurse prior to administering and proper documentation of nurse authorization was recorded. **Goal:** QMAs will obtain proper verbal authorization prior to administering all PRN medications and will document that verbal authorization was obtained prior to administering the PRN medication by 01/19/2024	

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	temperature elevation, pain, extreme anxiety, or agitation for which a "PRN" medication has been ordered, the qualified medication aide will notify the licensed nurse and obtain authorization to implement the 'PRN" order prior to administering the medication. The "PRN"medication will be documented in the resident's medication record...."			
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review and interview, the facility failed to ensure 1 of 1 nursing staff observed administering injectable medication followed professional standards of practice. (Employee 3) Finding includes: During a medication pass observation, conducted on 1/3/2023 between 7:20 A.M. - 9:30 A.M., LPN 3 prepared and administered Insulin Lispro and Insulin Lantus to Resident K. The nurse was noted to remove the cap from each insulin pen, clean the end of each pen with an alcohol swab and attach a disposable needle to each pen. She then dialed up the ordered doses, 6 units and 30 units respectively, and proceeded to administer the medication to Resident K. LPN 3 was did not prime either insulin pen prior to dialing the dose and administering the insulin. During an interview with LPN 3 on 1/3/2023 at 10:00 A.M. regarding the medication observation, she confirmed she had not primed either insulin	R 0296	**Interventions:** A mandatory in-service was conducted on 01/18/2024 for all employed nurses reviewing Hellenic Senior Living “Insulin Administration Clinical Policy and Procedure”. Each nurse will be required to sign with credentials and date they received the education and verbalized understanding of proper Insulin administration. Each individual nurse will be observed administering insulin, following Hellenic Senior Living Insulin Administration Clinical Policy and Procedure, by the DON/ADON or designated licensed nurse once weekly for one month then once monthly for two months and a record will be kept for each observation beginning 1/18/2024 records will be turned in to the	01/31/2024

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	pen. LPN 3 indicated the safety needle units utilized in the facility prevented the needles from being "primed." as they should have been. During an interview with the DON on 1/4/2023 at 10:45 A.M. she indicated the safety needles could be primed and should have been primed prior to dialing the ordered insulin doses for Resident K. She indicated the needles were more difficult to prime but could be primed and LPN 3 had been reeducated. The facility policy and procedure, titled, "Insulin Administration Clinical Policy and Procedure" included the following procedure: "...6. Dial a dose of 2 units to prime the pen. 7. Hold the pen with the needle pointing straight up and tap lightly so the bubbles will rise to the top. 8. Press the injection button all the way in and check to see that the insulin comes out of the needle. (If no insulin come out, repeat the test. If insulin still does not come out, get a new needle)...."		administrator/Executive director on all current nurses. to prevent this occurrence happening in the future all new hired Nurses will be observed administering 1 dose of insulin ensuring proper procedure is followed on their 1st day of training on the floor. **Goal:** All insulins administered will be primed prior to administering the insulin following Hellenic Senior Living Insulin Administration Clinical Policy and Procedure by 01/18/2024	
R 0297 Bldg. 00	410 IAC 16.2-5-6(c)(1) Pharmaceutical Services - Noncompliance (c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review and interview, the facility failed to ensure medications were obtained timely and administered timely for 3 of 5 residents observed receiving medications. (Residents K, J and L) and 1 of 5 clinical resident records reviewed (Resident F)	R 0297	**R 297** **Interventions:** A mandatory in-service was conducted on 01/18/2024 for all employed nurses and QMA's. Nurses and QMAs were educated that all scheduled and PRN medications that are not on the	01/19/2024

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	Findings include: During an observation of a medication pass, conducted on 1/3/2024 between 7:20 A.M. - 9:30 A.M., the following was noted: 1. LPN 3 administered morning medications to Resident K, including Refresh eye drops. The record for Resident K was reviewed on 1/3/2023 at 9:45 A.M. and the following medications had not been administered by LPN 3: Restasis .05 % eye drops one drop both eyes QID. The Medication Administration record indicated the Restasis eye drops were documented as given. During an interview with LPN 3 and observation of the medication cabinet contents for Resident K on 1/3/2023 at 10:00 A.M., she indicated the Restasis eye drops were not available, and she must have accidentally charted the Refresh eye drops in place of the Restasis eye drops. She would correct the error. She indicated Resident K received her medications from the facility's preferred pharmacy and she did not know why or how long the eye drops had not been available. The nursing staff was responsible for notifying the pharmacy of the need for a refill. 2. QMA 4 administered morning medications to Resident J. Resident J asked why she had not received an antibiotic and QMA 4 informed her it must be "done." The record for Resident J was reviewed on 1/3/2023 at 9:50 A.M. and the following medications had not been administered: the last dose of Nitrofuratoin/Macrodcrystal 100 mg and Refresh eye drops, two drops both eyes QID.		weekly roll pack must be reordered including eye drops. Reorder sticker will be removed from medications not included in the weekly roll pack provided by Pharmacy and placed on reorder form by nurse and QMA's and faxed to pharmacy no less than 7 days prior to last dose available to be given. Over the counter supplements that are not covered by insurance and resident/family refuse to pay bill resulting in pharmacy no longer sending the over the counter supplements will follow the following: primary physician will be notified of resident/family refusal to pay for over the counter supplement resulting in supplement not available. Nurse will request physician discontinue order for the over the counter supplement due to the fact supplement is not available due to resident refusing to purchase. Documentation with physician will be electronically charted under order note in PolintClick Care. The DON, ADON or designated licensed nurse will run missed medication report twice weekly for 1 month then once weekly for three months to ensure all medication is available and being given as ordered. If a missed medication or supplement shows as being missed the DON, ADON or designated nurse will ensure the missed medication or	

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	During an interview with LPN 3 and review of the Medication Administration Record for Resident J, she indicated the resident had received her first dose of a 7- day antibiotic order on the evening of 12/27/2023 and should have received the last dose in the morning on 1/3/2023. She indicated the Refresh eye drops were documented by QMA 4 as "Not Available." The Medication Administration Record for December 2023 and January 2024 indicated a majority of the doses had been marked either "9" (other) or "11" unavailable for the month of December and through 1/3/2024 of January. LPN 3 indicated she normally did not administered many oral medications so she was not aware of how long the medication had been unavailable. 3. QMA 4 administered morning medication to Resident L. The record for Resident L was reviewed on 1/3/2023 at 9:55 A.M. Resident L did not receive the ordered supplement Vitamin D3 - 1000 IU (international units) by mouth daily. During an interview with LPN 3 on 1/3/2023 at 10:00 A.M. she indicated QMA 4 had documented "11" (not available) for the medication. Review of the MAR for December 2023 and Jan 2024 indicated "11" was documented December 1- 10, 27 - 31 and Jan 1 - 3. 4. The clinical record for Resident F was reviewed on 1/2/2023 at 11:00 A.M. Resident F had Physician Orders for the pain medication Tramadol 50 mg twice a day with a diagnosis of chronic pain. The Nursing Progress Notes for December 2023 and January 2024 documented several times the medication was not available, and the nurse and physician had been notified. The Medication Administration Record for December 2023 and January 2024 indicated the		supplement is obtained or discontinued by physician and document in resident record under order notes the outcome. Report will be ran daily beginning 01/19/2024 **Goal:** Residents will not have any missed medications beginning 1/19/2024	

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	resident had not received the ordered routine pain medication since December 18, 2023. During an interview with the Director of Nursing on 1/3/2024 at 2:30 P.M. she indicated one of the two missing bottles of eye drops had been located on a top shelf of the medication cabinet, the other bottle had been reordered from pharmacy, the son of Resident L had been notified of the need to purchase the Vitamin D 3 from a pharmacy and bring the medication to the facility, the last dose of the antibiotic for Resident J had been pulled from the Pyxis system and administered, and the physician had been notified of the need for a new narcotic prescription for the Tramadol pain medication for Resident F. When asked if she was responsible for ensuring medications and ordered supplements were available to be dispensed, she indicated she often did not know of issues with medications being available if the issues occurred on the weekends or when she was not in the building. During an interview with the Administrator on 1/4/2204 at 1:20 P.M. she indicated the Nurse Practitioner who had ordered the Tramadol for Resident F was a "new prescriber" and the pharmacy had only filled 7 days' worth instead of 30 days' worth. She indicated after the issue was brought to their attention, on 1/3/2024, the nurse practitioner had been notified of the need to send in a new prescription for Resident F. There was no explanation why there was no follow up regarding the medication issue for Resident F. The new prescription had been sent in on 1/3/2024. She also indicated the Resident L's son had been notified yesterday, 1/3/2024 of the need to buy the Vitamin D 3 supplement as their pharmacy was not supplying over the counter medications and/or supplements due to			

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	non-payment issues in the past. There was no information given regarding the missing eye drop for Resident K or Resident J. The facility policy and procedure, titled, "Medication, Ordering and Receiving from Pharmacy" provided by the Administrator on 1/4/2023 at 1:15 P.M. included the following: "a. 2. Repeat medications (refills) are written on a medication order form/ordered by peeling the bottom label from the prescription label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: a) Reorder medication three to four days in advance of need to assure an adequate supply is on hand. When reordering medications that requires special processing (such as Schedule II- controlled substance), order at least five to seven days in advance of need.....g. 2. If nursing requires a schedule II - controlled substance to be dispensed, or authorized form the emergency supply, but pharmacy does not have a valid prescription to dispense then nursing must contact the prescriber to have a prescription transmitted or delivered immediately to pharmacy, or an emergency prescription called into a pharmacist..." The policy and procedure, titled, "Hellenic Senior Living Clinical Policy and Procedure" included the following: "Procedure: 1. The Director of Nursing will ensure that medication related services required or requested by each resident are provided...." The policy and procedure, titled, "Medication Administration" included the following Procedure: "...32. The Director of Nursing will be notified when prescribed medications are not available to be administered at the scheduled time. The			

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	Director of Nursing will be responsible for investigating the reason medication(s) are not available, and for taking corrective actions to ensure medications are available as prescribed...." There was no documentation the Director of Nursing had initiated corrective action prior to being made aware of the issues on 1/3/2024.			
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure the clinical records had medical diagnoses accurately documented for 1 of 5 residents reviewed. (Resident F) Finding includes: The clinical record for Resident F was reviewed on 1/2/2024 at 2:00 P.M. Resident F had diagnoses, including but not limited to, Major Depressive Disorder, recurrent. The psychiatric mental health history, mental health screening assessment and a care plan to address the resident's Major Depressive Disorder, recurrent, were not located in the clinical record. During an interview with the Administrator on 1/4/2023 at 1:20 P.M. she indicated, after reviewing all the documentation, including the	R 0349	**Interventions:** The admission audit form will be used by the DON/ADON or nurse completing a new admission which includes ensuring correct diagnosis with ICD 10 codes are entered as listed on the history and physical for signed by the primary physician prior to admission. The audit form will be initialed on each line and signed with credentials and date when completed. first audit will be completed no later than 24 hours following admission to community. A second audit will be completed by the DON/ADON or nurse other than the nurse who completed the admission and	01/31/2024

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	pre-admission evaluation documentation from the resident's previous physician, the resident did not have a diagnosis of Major Depressive Disorder, recurrent but instead had a diagnosis of Depression, mild. When the resident was admitted, the ICD (International Statistical Classification of Diseases and Related Health Problem) codes were entered and whoever put the documentation into the resident's clinical record must have made an error. The post admission medical documentation included the Major Depressive Disorder, recurrent diagnosis and indicated the resident was receiving Trazodone and Cymbalta (both antidepressants) to address the disorder. The Administrator indicated there was no specific policy regarding accurately documenting admission diagnoses.		entered the diagnosis with correct ICD 10 codes to ensure accuracy matching the admission history and physical signed by the primary physician prior to admission. The audit form will be initialed on each line and signed with credentials and date when completed. completed audit forms for each admission will be submitted to the Administrator/Executive Director no later than 48 hours following admission. The use of Audit Forms will be required for every admission following the process listed above with no end date making it part of the admission process **Goal:** All Medical Diagnosis will be accurately recorded in the resident's record as of 01/19/2024	