STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 00 B. WING	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00357754, IN00358363 and IN00358958. Complaint IN00357754 - Unsubstantiated due to lack of evidence. Complaint IN00358363 - Unsubstantiated due to lack of evidence. Complaint IN00358958 - Substantiated. Federal/state deficiencies related to the allegations are cited at F755 and F842. Survey dates: August 4 and 5, 2021 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census bed type: SNF/NF: 104 Total: 104 Census payor type: Medicare: 6 Medicaid: 81 Other: 17 Total: 104 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 11, 2021	F 0000		
F 0755 SS=E	483.45(a)(b)(1)-(3) Pharmacy			

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

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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Bldg. 00	Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based on interview and record review, the facility failed to ensure narcotic medications were documented, as administered, and documented with dosage and frequency per the physician orders for 4 of 4 residents reviewed for medication	F 0755	**F755 Pharmacy Services/Procedures/Pharmacist/Records** **Corrective action for the resident(s) found to have been affected by the deficient**	08/22/2021

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	administration. (Resident B, D, E and G) Findings include: 1a. The clinical record for Resident B was reviewed on 8/5/21 at 12:57 p.m. The diagnoses included, but were not limited to, gout, osteoarthritis, and anxiety disorder. A physician order, dated 1/28/21, indicated the following, "...Klonopin tablet 1 mg [milligram]...Give 1 tablet by mouth every 6 hours for Anxiety...." A "controlled drug administration record" for Resident B's Klonopin, dated 5/27/21 to 6/3/21, noted no documentation of the time the medication was administered on 5 of 30 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 6/4/21 to 6/11/21, noted no documentation of the time the medication was administered on 2 of 30 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 6/26/21 to 7/4/21, noted no documentation of the time the medication was administered on 4 of 30 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 7/4/21 to 7/11/21, noted no documentation of the time the medication was administered on 4 of 30 administrations. There was an additional dose of Klonopin given on 7/6/21 for a total of 5 doses administered, instead of 4 per physician order.		**practice:** Residents D and G no longer reside in the facility. Resident B was identified as being part of the facilities deficient practice. Resident E was identified as being part of the facilities deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents whom are prescribed narcotics have the potential to be affected by the deficient practice. An audit has been conducted of all residents whom receive narcotics and a pain assessment was completed to ensure those resident have not been affected by the facilities deficient practice. Any identified concerns were immediately addressed. **Measures/ systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee have completed education with licensed nurses and qualified medication aides using “Medication Administration” policy to ensure documentation of medications as administered, with dosage and frequency per MD order. **Corrective actions to be monitored to ensure the deficient practice does not**	

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	A "controlled drug administration record" for Resident B's Klonopin, dated 7/11/21 to 7/19/21, noted no documentation of the time the medication was administered on 3 of 30 administrations. There were no controlled drug administration record for Resident B's Klonopin to account for the time period of 7/19/21 to 7/26/21. A physician order, dated 7/29/21, indicated the following, "...Klonopin tablet 1 mg...Give 1.5 mg by mouth one time a day for Anxiety AND Give 1 mg by mouth one time a day for Anxiety AND Give 1 mg by mouth one time a day for Anxiety AND Give 1.5 mg by mouth one time a dayfor Anxiety...." A "controlled drug administration record" for Resident B's Klonopin, dated 7/26/21 to 8/1/21, noted no documentation of the time the medication was administered on 2 of 28 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 8/2/21 to 8/4/21, noted no documentation of the time the medication was administered on 2 of 10 administrations. There were only partial doses of 1 mg of Klonopin documented as administered instead of the 1.5 mg dose, per the physician orders, on 8/3/21 and 8/4/21. 1b. A physician order, dated 4/28/21, indicated the following, "...oxycodone...30 mg...Give 1 tablet by mouth every 4 hours for chronic pain...." A "controlled drug administration record" for Resident B's oxycodone, dated 6/26/21 to 7/1/21, noted no documentation of the time the		**recur:** The Director of Nursing/Designee will audit resident's records whom are prescribed narcotics to ensure accurate documentation of medications as administered including dosage and frequency per MD order. The audit will occur as follows: 5 residents per week x4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week, 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be addressed. The Director of Nursing will present the results of the audits monthly to QAPI committee for no less than 3 months. Any patterns that are identified will have an Action plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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medication was administered on 7 of 30 administrations.

A "controlled drug administration record" for Resident B's oxycodone, dated 7/1/21 to 7/5/21, noted no documentation of the time the medication was administered on 2 of 20 administrations.

A "controlled drug administration record" for Resident B's oxycodone, dated 7/5/21 to 7/8/21, noted no documentation of the time the medication was administered on 2 of 20 administrations.

A "controlled drug administration record" for Resident B's oxycodone, dated 7/8/21 to 7/13/21, noted no documentation of the time the medication was administered on 5 of 30 administrations.

A "controlled drug administration record" for Resident B's oxycodone, dated 7/18/21 to 7/23/21, noted administration of oxycodone 30 milligrams given twice on 7/23/21 at 6:00 a.m.

A physician order, dated 8/2/21, indicated the following, "...oxycodone...30 mg...Give 1 tablet by mouth every 3 hours for chronic pain...."

A "controlled drug administration record" for Resident B's oxycodone, dated 8/2/21 to 8/5/21, noted no documentation of the time the medication was administered on 6 of 24 administrations.

An interview conducted with Minimum Data Set (MDS) Nurse 4, on 8/5/21 at 4:21 p.m., indicated she was unable to locate the missing administration record for Resident B's Klonopin

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from 7/19/21 to 7/26/21.

2. The clinical record for Resident D was reviewed on 8/5/21 at 1:00 p.m. The diagnoses included, but were not limited to, weakness, anxiety disorder, and major depressive disorder. Resident D was admitted to the facility on 7/14/21 and discharged on 7/22/21.

A physician order, dated 7/15/21, indicated the following, "...Methadone...10 mg...Give 8 tablet by mouth one time a day for pain...."

There were no controlled drug administration records present in Resident D's chart in regards to the physician order for Methadone.

An interview conducted with MDS Nurse 4, on 8/5/21 at 4:58 p.m., indicated there were no controlled administration records that could be located for Resident D's Methadone during her stay at the facility.

3. The clinical record for Resident E was reviewed on 8/5/21 at 1:29 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, arthritis, and neuropathy.

A physician order, dated 7/18/21, indicated the use of a Fentanyl patch, 75 micrograms, to be applied transdermally every 48 hours for pain.

A physician order, dated 2/2/21, indicated the use of Lyrica 100 milligrams twice daily for seizures.

A "controlled drug administration record" for Resident E's Lyrica, dated 6/23/21 to 7/7/21, noted no documentation of the time the medication was administered on 4 of 30 administrations.

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A "controlled drug administration record" for Resident E's Lyrica, dated 7/9/21 to 7/27/21, noted no documentation of the time the medication was administered on 1 of 30 administrations. There wasn't an administration signed off for the 7/21/21 for the morning dose.

A "controlled drug administration record" for Resident E's Fentanyl patches, dated 6/28/21 to 7/8/21, noted no documentation of administration of the Fentanyl patch for 7/6/21.

4a. The clinical record for Resident G was reviewed on 8/5/21 at 1:12 p.m. The diagnoses included, but were not limited to, cervical disc degeneration, weakness, chronic pain, and anxiety disorder.

A physician order, dated 6/2/21, indicated the use of Klonopin 0.25 milligrams three times daily for anxiety.

A physician order, dated 6/30/21, indicated the use of Klonopin 0.5 milligrams three times daily for anxiety.

The "controlled drug administration record" for Resident G's Klonopin noted the following date(s)/time(s) where the medication was not signed off, as administered:

6/20/21- afternoon dose,
7/9/21- night time dose,
7/17/21- afternoon dose, &
7/25/21- night time dose.

4b.A physician order, dated 5/14/21, indicated the use of Morphine 15 milligram extended release tablet every 12 hours for pain.

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The "controlled drug administration record" for Resident G's extended release Morphine noted the following date(s)/time(s) where the medication was not signed off, as administered:

6/2/21- morning dose,
6/6/21- night time dose,
6/7/21- night time dose,
6/8/21- night time dose,
6/11/21- night time dose,
6/12/21- night time dose,
6/14/21- both morning and night time dose, &
7/10/21- night time dose,

On 7/24/21, the extended release Morphine was signed off, as administered, of 3 doses within a 24 hour period instead of 2 doses as ordered.

4c. A physician order, dated 5/14/21, indicated the use of Lyrica 225 milligrams twice daily.

The "controlled drug administration record" for Resident G's Lyrica noted the following date(s)/time(s) where the medication was not signed off, as administered:

7/6/21- night time dose &
7/26/21- morning dose.

On 7/25/21, the Lyrica was signed off for 3 administrations within a 24 hour period instead of 2 doses as ordered.

An interview conducted with MDS Nurse 4, on 8/5/21 at 4:58 p.m., indicated the empty medication card goes along with the controlled drug administration record into a filing system for review to ensure the resident has the medication available for continued use. Narcotic count sheets should be completed and consistent with

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	physician orders. A policy titled "Medication Controlled Drugs and Security", revised 7/15/18, was provided by MDS Nurse 4 on 8/5/21 at 5:00 p.m. The policy indicated the following, "...Procedure...IV. The Narcotic Count and Inventory...c. The inventory of the controlled drugs, count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count...." A policy titled "Medication Administration", revised 12/14/17, was provided by MDS Nurse 4 on 8/5/21 at 11:00 a.m. The policy indicated the following, "...Procedure...I. General Procedures...a. Administer medication only as prescribed by the provider...f. Observe the "five rights" in giving each medication...ii. the right time...iv. the right dose...ee. Narcotics will be signed out when given...ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered...Documentation...a. Documentation of medication will be current for medication administration...b. Documentation of medications will follow accepted standards of nursing practice...." This Federal tag relates to Complaint IN00358958.			
F 0842 SS=E Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.			

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	§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or			

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	(ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure documentation included times of medication administration of narcotic medication and have narcotic count sheets to provide completed reconciliation of narcotics for 4 of 4 residents reviewed for medication administration. (Resident B, D, E, and G) Findings include: 1a. The clinical record for Resident B was reviewed on 8/5/21 at 12:57 p.m. The diagnoses included, but were not limited to, gout, osteoarthritis, and anxiety disorder. A physician order, dated 1/28/21, indicated the following, "...Klonopin tablet 1 mg [milligram]...Give 1 tablet by mouth every 6 hours for Anxiety...."	F 0842	**F842 RESIDENT RECORDS** Corrective action for the resident(s) found to have been affected by the deficient practice: Residents D and G no longer reside in the facility. Resident B was identified as being part of the facilities deficient practice. Resident E was identified as being part of the facilities deficient practice. **Corrective action taken for those residents having the potential to be affected by the same deficient practice:** All residents whom are prescribed narcotics have the potential to be affected by the deficient practice. An audit has been conducted of all residents whom receive narcotics	08/22/2021

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	A "controlled drug administration record" for Resident B's Klonopin, dated 5/27/21 to 6/3/21, noted no documentation of the time the medication was administered on 5 of 30 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 6/4/21 to 6/11/21, noted no documentation of the time the medication was administered on 2 of 30 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 6/26/21 to 7/4/21, noted no documentation of the time the medication was administered on 4 of 30 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 7/4/21 to 7/11/21, noted no documentation of the time the medication was administered on 4 of 30 administrations. There was an additional dose of Klonopin given on 7/6/21 for a total of 5 doses administered, instead of 4 per physician order. A "controlled drug administration record" for Resident B's Klonopin, dated 7/11/21 to 7/19/21, noted no documentation of the time the medication was administered on 3 of 30 administrations. There were no controlled drug administration record for Resident B's Klonopin to account for the time period of 7/19/21 to 7/26/21. A physician order, dated 7/29/21, indicated the following, "...Klonopin tablet 1 mg...Give 1.5 mg by mouth one time a day for Anxiety AND Give 1 mg by mouth one time a day for Anxiety AND		to ensure those resident have not affected by the facilities deficient practice. Any identified concerns were immediately addressed. **Measures/ systemic changes put into place to ensure the deficient practice does not recur:** The Administrator/Director of Nursing/Designee have completed education with licensed nurses and qualified medication aides using "Medication Administration" policy to ensure accurate documentation of medications at time of administration on EMAR and Narcotic count sheets for reconciliation by 8/22/21. **Corrective actions to be monitored to ensure the deficient practice does not recur:** The Director of Nursing/Designee will audit resident's records whom are prescribed narcotics to ensure accurate documentation of medications as administered including time of administration on EMAR and Narcotic Count sheet for reconciliation. The audit will occur as follows: 5 residents per week x4 weeks, then 3 residents per week x 4 weeks, then 1 resident per week, 4 weeks for no less than 3 months and compliance is maintained. Any identified concerns will be addressed. The Director of Nursing will present the results of the audits	

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	Give 1 mg by mouth one time a day for Anxiety AND Give 1.5 mg by mouth one time a dayfor Anxiety...." A "controlled drug administration record" for Resident B's Klonopin, dated 7/26/21 to 8/1/21, noted no documentation of the time the medication was administered on 2 of 28 administrations. A "controlled drug administration record" for Resident B's Klonopin, dated 8/2/21 to 8/4/21, noted no documentation of the time the medication was administered on 2 of 10 administrations. 1b. A physician order, dated 4/28/21, indicated the following, "...oxycodone...30 mg...Give 1 tablet by mouth every 4 hours for chronic pain...." A "controlled drug administration record" for Resident B's oxycodone, dated 6/26/21 to 7/1/21, noted no documentation of the time the medication was administered on 7 of 30 administrations. A "controlled drug administration record" for Resident B's oxycodone, dated 7/1/21 to 7/5/21, noted no documentation of the time the medication was administered on 2 of 20 administrations. A "controlled drug administration record" for Resident B's oxycodone, dated 7/5/21 to 7/8/21, noted no documentation of the time the medication was administered on 2 of 20 administrations. A "controlled drug administration record" for Resident B's oxycodone, dated 7/8/21 to 7/13/21,		monthly to QAPI committee for no less than 3 months. Any patterns that are identified will have an Action plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	155188	A. BUILDING 00 B. WING	08/05/2021

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noted no documentation of the time the medication was administered on 5 of 30 administrations.

A physician order, dated 8/2/21, indicated the following, "...oxycodone...30 mg...Give 1 tablet by mouth every 3 hours for chronic pain...."

A "controlled drug administration record" for Resident B's oxycodone, dated 8/2/21 to 8/5/21, noted no documentation of the time the medication was administered on 6 of 24 administrations.

An interview conducted with Minimum Data Set (MDS) Nurse 4, on 8/5/21 at 4:21 p.m., indicated she was unable to locate the missing administration record for Resident B's Klonopin from 7/19/21 to 7/26/21.

2. The clinical record for Resident D was reviewed on 8/5/21 at 1:00 p.m. The diagnoses included, but were not limited to, weakness, anxiety disorder, and major depressive disorder. Resident D was admitted to the facility on 7/14/21 and discharged on 7/22/21.

A physician order, dated 7/15/21, indicated the following, "...Methadone...10 mg...Give 8 tablet by mouth one time a day for pain...."

There were no controlled drug administration records present in Resident D's chart in regards to the physician order for Methadone.

An interview conducted with MDS Nurse 4, on 8/5/21 at 4:58 p.m., indicated there were no controlled administration records that could be located for Resident D's Methadone during her stay at the facility.

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3. The clinical record for Resident E was reviewed on 8/5/21 at 1:29 p.m. The diagnoses included, but were not limited to, chronic pain syndrome, arthritis, and neuropathy.

A physician order, dated 7/18/21, indicated the use of a Fentanyl patch, 75 micrograms, to be applied transdermally every 48 hours for pain.

A physician order, dated 2/2/21, indicated the use of Lyrica 100 milligrams twice daily for seizures.

A "controlled drug administration record" for Resident E's Lyrica, dated 6/23/21 to 7/7/21, noted no documentation of the time the medication was administered on 4 of 30 administrations.

A "controlled drug administration record" for Resident E's Lyrica, dated 7/9/21 to 7/27/21, noted no documentation of the time the medication was administered on 1 of 30 administrations.

4a. The clinical record for Resident G was reviewed on 8/5/21 at 1:12 p.m. The diagnoses included, but were not limited to, cervical disc degeneration, weakness, chronic pain, and anxiety disorder.

A physician order, dated 6/2/21, indicated the use of Klonopin 0.25 milligrams three times daily for anxiety.

A physician order, dated 6/30/21, indicated the use of Klonopin 0.5 milligrams three times daily for anxiety.

The "controlled drug administration record" for Resident G's Klonopin noted the following date(s)/time(s) where the medication was not

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signed off, as administered:

6/20/21- afternoon dose,
7/9/21- night time dose,
7/17/21- afternoon dose, &
7/25/21- night time dose.

4b.A physician order, dated 5/14/21, indicated the use of Morphine 15 milligram extended release tablet every 12 hours for pain.

The "controlled drug administration record" for Resident G's extended release Morphine noted the following date(s)/time(s) where the medication was not signed off, as administered:

6/2/21- morning dose,
6/6/21- night time dose,
6/7/21- night time dose,
6/8/21- night time dose,
6/11/21- night time dose,
6/12/21- night time dose,
6/14/21- both morning and night time dose, &
7/10/21- night time dose,

4c. A physician order, dated 5/14/21, indicated the use of Lyrica 225 milligrams twice daily.

The "controlled drug administration record" for Resident G's Lyrica noted the following date(s)/time(s) where the medication was not signed off, as administered:

7/6/21- night time dose &
7/26/21- morning dose.

An interview conducted with MDS Nurse 4, on 8/5/21 at 4:58 p.m., indicated the empty medication card goes along with the controlled drug administration record into a filing system for

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	review to ensure the resident has the medication available for continued use. Narcotic count sheets should be completed and consistent with physician orders. A policy titled "Medication Controlled Drugs and Security", revised 7/15/18, was provided by MDS Nurse 4 on 8/5/21 at 5:00 p.m. The policy indicated the following, "...Procedure...IV. The Narcotic Count and Inventory...c. The inventory of the controlled drugs, count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count...." A policy titled "Medication Administration", revised 12/14/17, was provided by MDS Nurse 4 on 8/5/21 at 11:00 a.m. The policy indicated the following, "...Procedure...I. General Procedures...a. Administer medication only as prescribed by the provider...f. Observe the "five rights" in giving each medication...ii. the right time...iv. the right dose...ee. Narcotics will be signed out when given...ff. Medications will be administered within the time frame of one hour before up to one hour after time ordered...Documentation...a. Documentation of medication will be current for medication administration...b. Documentation of medications will follow accepted standards of nursing practice...." This Federal tag relates to Complaint IN00358958.			