STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155828	A. BUILDING _____ B. WING _____	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE POINTE OF FORT WAYNE	5250 HERITAGE PARKWAY FORT WAYNE, IN 46835

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00388472. Complaint IN00388472 - Substantiated. Federal and State deficiency related to the allegation is cited at F602. Survey date: September 22, 2022 Facility number: 012931 Provider number: 155828 AIM number: 201278730 Census Bed Type: SNF/NF: 51 Residential 19 Total: 70 Census Payor Type: Medicare: 3 Medicaid: 18 Other: 30 Total: 51 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 27, 2022.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 602		

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

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F 602	Continued From page 1 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a resident's narcotic medication was not misappropriated by a facility nurse for 1 of 3 resident medications reviewed for misappropriation. (Resident B) Findings include: The clinical record for Resident B was reviewed on 9/22/2022 at 11:00 A.M. The diagnoses included, but were not limited to, aftercare following joint replacement, osteoarthritis, and muscular weakness. A physician's order, dated 8/11/2022, indicated the resident was to receive oxycodone HCl tablet 10 mg (milligram), give 1 tablet by mouth every 4 hours as needed for (prn) moderate to severe pain of 6 to 10. The resident was to rate the level of pain based on a 1 being low and 10 being severe pain. The order indicated it was discontinued, but was lacking a discontinued date. A physician's order, dated 8/11/2022, indicated the resident was to receive oxycodone HCl tablet 10 mg, give 0.5 tablet (half of the tablet) by mouth every 4 hours as needed for moderate to severe pain 1 to 5 scale. The order indicated it was discontinued, but was lacking a discontinued date. A physician's order, dated 8/12/2022, indicated the resident was to receive oxycodone HCl tablet	F 602	Past noncompliance: no plan of correction required.	

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10 mg, give 1 tablet by mouth every 4 hours as needed for moderate to severe pain of a 6 to 10. The order had a discontinued date of 8/18/2022 and indicated it was completed.

A physician's order, dated 8/12/2022, indicated the resident was to receive oxycodone HCl tablet 10 mg, give 0.5 tablet by mouth every 4 hours as needed for moderate to severe pain on a 1 to 5 scale. The order had a discontinued date of 8/18/2022 and indicated it was completed.

A physician's order, dated 8/19/2022, indicated the resident was to receive oxycodone HCl tablet 10 mg, give 1 tablet by mouth every 4 hours as needed for moderate to severe pain of a 6 to 10 level for 14 days. The order had a discontinued date of 9/2/2022.

A physician's order, dated 8/19/2022, indicated the resident was to receive oxycodone HCl tablet 10 mg, give 0.5 tablet by mouth every 4 hours as needed for moderate to severe pain on a 1 to 5 scale for 14 days. The order had a discontinued date of 9/2/2022.

Review of the August 2022 MAR (Medication Administration Record) and the Pharmacy Controlled Substance Records for Resident B, indicated LPN (Licensed Practical Nurse) 1 documented on 8/18/2022 at 6:00 P.M. 2 half tablets of oxycodone were wasted/dropped. On 8/18/2022 at 6:00 P.M., she documented 2 half tablets were signed out and administrated. On 8/19/2022, at 2:00 A.M., she signed off 2 half tablets of oxycodone, but the MAR was lacking documentation the medications were administered.

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Review of the facility's incident report indicated LPN 1 had allegation of missing oxycodone for Resident B. The investigation was completed and found the torn missing oxycodone medication blister card for 10 tablets of Oxycodone. The blister card was delivered to the facility on 8/19/2022 and was found in the shred bin in the Nurse's Room on the unit.

Review of LPN 2's statement, written on 8/20/2022, indicated she had received a card of whole tablets of oxycodone from the Pharmacy delivery man at the front desk. When she got back to the unit, she immediately went to Resident B's room and told them that they had received 10 whole tablets. The resident would have enough pain medications until her next delivery. LPN 1 had called the Pharmacy to get an authorization code to get the oxycodone from the EDK (Emergency Drug Kit) but the pharmacist indicated the medication was not in the EDK. LPN 2 requested the medication to be delivered stat (immediately). After she had shown Resident B the medication card that was delivered, the medication were put in the narcotic box, the count sheet was placed in the book and she filed the pink delivery status sheet in the filing cabinet. When LPN 1 came into replace her at shift change, she informed LPN 1 the oxycodone for Resident B had come. LPN 1 cosigned the pink controlled substance record by her name and placed the sheet in the narcotic book. On Saturday morning she was in the Chadwick Unit and heard Resident B discussing her pain medications with LPN 3. The resident made a comment about only having half tablets. She asked LPN 3 about the whole oxycodone tablets. LPN 3 indicated there was a card of half tables in the narcotic drawer, no whole tablets. They went

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to look for the medication. In the unit office in the medical record box was the delivery sheet for oxycodone 10 mg tablets for 2 tablets, which were already administered. When LPN 2 realized the oxycodone card was not accounted for she immediately called the executive director. The written statement was signed by LPN 2 and dated 8/20/2022

Review of LPN 3's statement, written on 8/20/2022, indicated when she had started her shift, she and LPN 1 counted the narcotics. She had signed the narcotic book for 3 count sheets and 3 medication cards. Resident B was requesting pain medications and she gave the resident 2 half tablets of oxycodone. Resident B was upset with her for not giving her a whole tablet. Around 11:00 A.M., she was talking with Resident B about the half tablets verses whole tablet and LPN 2 overheard them. LPN 2 knew Resident B had had whole tablets. When they realized the medication was gone and no paperwork was in the medical records, LPN 2 called the Administrator because she had received a stat delivery of whole tablets yesterday. The written statement as signed by LPN 3.

During an interview with the Administrator on 9/22/2022 at 11:00 A.M., he indicated the reported incident occurred and was investigated. They had reviewed the security camera's video on the unit. The video showed LPN 1 open the narcotic box in the medication cart, she took a medication cup and was observed to go into the therapy gym on the unit. No cameras were in the therapy gym, but LPN 1 was in the gym for about 11 minutes and them was observed to go into the Nurses' Room. The shred bin in the Nurse's room

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was searched and part of the medication card and the delivery receipt from the 1:40 A.M. oxycodone order was found. No medications were found in the shred bin. The LPN had called the facility NP, for a new order for the oxycodone 10 mg half tablets for 14 days on 8/19/2022 around 2:00 AM. The order was written and entered in system at 3:57 AM.

During an interview with LPN 2 on 9/22/2022 at 1:15 P.M., she indicated she had received Resident B's oxycodone on Friday afternoon, 8/19/2022. She had stopped by the resident's room to let her know she had received 10 whole tablets. She usually did not inform residents when their medication arrive, but the resident was worried about running out of the medication. She heard LPN 3 and Resident B talking and about the resident not having oxycodone whole tablets. She and LPN 3 searched everywhere for the resident's oxycodone whole tablets medication card and count sheet, they looked for the pink delivery receipt, none of them were found. They called the Administrator when they could not find the medication card.

During an interview with LPN 3 on 9/22/2022 at 3:00 P.M.,she indicated she had worked on the Chadwick Unit on Saturday 8/20/2022. She moved to the unit around 6:30 A.M. when an agency staff called off. She had counted the narcotics with Nurse 1 when she came to the unit. The narcotic count was correct with the correct number of cards and count sheets. Resident B asked about getting a whole tablet instead of 2 half tablets and she told her only half tablets were available. LPN 2 overheard us and said she had received whole tables Friday afternoon. Both her and LPN 2 searched everywhere for the

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medication. When they could not find the medication LPN 2 called the Administrator.

During an interview with the DON, on 9/22/2022 at 1:00 P.M., she indicated all Nurses and QMAs were educated on 8-29-2022 on professional conduct, drug diversion, records and variances of narcotic and controlled drugs, including drug security, accurate inventory counts and timely and accurate completion of narcotic registers and policy and procedures on any unresolved inventory or discrepancies was to be reported to the DON immediately and investigated. Staff were also educated to verifying the accuracy of the narcotic counts was completed by 2 licensed nurses or QMA. The DON also provided Quality Assurance Audits for the Narcotic Count Sheets, which began on 9/9/2022 for 3 times a week and was completed 3 times a week and required correction during 2 audits.

Review of a current facility policy, provided by the Administrator on 9/22/2022 at 11:00 AM, titled, Drug Diversion, dated 2/9/2018, indicated, "...To maintain security of all medication housed and dispensed by...follow all state and federal guideline in the storage and dispensing of all medications that are the responsibility of the facility. In the event a staff member becomes aware that there is medication missing they will contact the DON or House Supervisor immediately...1. Search medication cart, floor, medication room and immediate area for the missing medication...Immediately contact the DON and Administrator if not already done...Drug screen all employee having access to the missing medications during the time frame the medicated is thought to be missing. Employees that refuse testing may be subject to termination...Initiate

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investigation...Fill out abuse investigation forms [misappropriation of resident property] and send to IDSH..Contact local policy...Replace the missing drugs at the facility's expense...Notify dispensing pharmacy...Consider QAPI (Quality Assurance Performance Improvement) to ensure drug diversion does not reoccur...."

Review of a current facility policy, provided by the Administrator, on 9/22/2022 at 5:04 p.m., titled, Abuse, Neglect and Exploitation, revision date 9/2022, indicated, "...It is the policy of this facility to provide protections for the health,, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property..."Misappropriation of Resident Property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent...Screening...Training...Prevention of Abuse, Neglect and Exploitation...Identification of Abuse, Neglect and Exploitation...Investigation of Alleged Abuse, Neglect and Exploitation...Protection of Resident...Reporting/Response...Coordination with QAPI...."

The deficient practice was corrected by 9/9/22 after the facility implemented a systemic plan that included the following actions: completed investigation; all residents controlled medication records were reviewed; staff were educated; and auditing/monitoring was started prior to the start of the survey.

This Federal tag relates to Complaint

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