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	05/22/2024

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00433605, IN00433930, and IN00433998. Complaint IN00433605 - State deficiencies related to the allegations are cited at R0006, R0214, R0216, R0241. Complaint IN00433930 - State deficiencies related to the allegations are cited at R00214, R0216 and R0241. Complaint IN00433998 - State deficiencies related to the allegations are cited at R00214, R0216 and R0241. Survey date: May 21 and 22, 2024 Facility number: 004440 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 24, 2024	R 0000		
R 0006 Bldg. 00	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency Based on interview and record review, the facility failed to assess a resident's condition to ensure resident needs could be safely met for 1 of 3 residents reviewed (Resident F). Findings include: On 5/21/24 at 11:23 A.M., Resident F's record was	R 0006	**·What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** On 6/8/2024, Care Plan for Resident F was reviewed by Director of Health & Wellness for	06/30/2024

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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	reviewed. Diagnoses included diabetes, coronary artery disease, high blood pressure, and right heel wound. A pre-admission evaluation, dated 3/22/24, completed prior to his hospitalization, indicated the resident was independent with mobility and transfers. He had incontinence but was independent in managing. He was independent with bathing, dressing, and grooming himself. He had no wounds and hadn't required home health services. A hospital note, dated 4/24/24 at 3:00 p.m., indicated the resident had been brought to the hospital and hospitalized 4/22-4/24/24. His family member indicated the resident had been residing at a skilled facility where the resident developed a pressure ulcer to his right heel. The resident was weak, non-compliant, agitated, and medically non-compliant. He was admitted for failure to thrive, debility, multiple pressure ulcers and a right heel wound with decreased pulses. A doppler study to his right leg was completed and found to be abnormal with decreased blood flow to the heel. He was not a candidate for treatment due to heart and kidney disease. Post Discharge orders from the hospital, dated 4/24/24, indicated the resident needed referral to the wound clinic for treatment of a pressure ulcer on his right heel. He needed referral to home health, physical and occupational therapies. He had a wound to his bottom requiring treatment twice daily and close monitoring. A nurse note, dated 4/24/24 at 4:15 p.m., indicated the resident had arrived at the facility with family. He had a pressure area to his right heel which was black in color with brown skin surrounding the		accuracy and completion. Care plan was updated appropriately to reflect all needs and services required to ensure compliance **·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** All Residents residing in the facility have the potential to be affected that may experience change in condition or hospital stay greater than 24 hrs. Going forward, all new admissions or readmissions with change in condition will be assessed by Director of health & Wellness to reflect any changes and no resident will be received from the hospital until the reassessment has been completed and determined they are appropriate for assisted living **·What measures will be put into place or systemic changes to occur to ensure that the deficient practice does not reoccur** Tracking sheets have been initiated by the Director of wellness to ensure that the facility is following and taking appropriate measures for completing care plans Tracking sheets include: Hospital stays Change in condition	

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	wound. The family member reported the resident had an open wound on his back which was unable to be assessed at the time. There was no assessment or documentation of the resident's wounds to his right heel, back, or buttocks. A nurse note, dated 4/30/24 at 7:00 a.m., indicated the resident was found to have an open area to his coccyx. He was educated on need to take pressure off the area. The NP (Nurse Practitioner) was to evaluate the wound on 5/1/24. A MAR (Medication Administration Record) dated May 2024, indicated an order, dated 5/1/24, for Mepilex border to be applied to the resident's right heel and coccyx . It was to be changed every 3 days and as needed for soiling. An NP note, dated 5/1/24, indicated the resident was visited for chronic health issues. He had been refusing his blood pressure medications, had muscle weakness and decreased mobility. The resident had a deep tissue injury (DTI) to his right heel. The area was being managed by the wound care team. Assessment and Plan: Right heel DTI: resident was to keep pressure off of heels at all times; staff were to monitor for worsening and the wound care team would continue to follow. The NP note hadn't indicated the resident had an open area on his coccyx and no evaluation of the wound was completed. An order and referral, dated 5/1/24, was for wound evaluation and treatment for the resident's buttocks and right heel. The order was sent to a home health agency. A Service Plan, dated 5/9/24, indicated the resident had chronic health issues not managed and followed by a physician. He had no acute		Wounds Current Third Party A resident Kardex has been put into place that states specific needs for each resident to allow for all clinical staff to view based on resident needs and allows for Director of Health & Wellness to clearly note in order to update care plans appropriately On 6/15/24 the Director of Health & Wellness will initiate an educational Inservice resident Kardex binder, communication if items are missing from the Kardex, or if a condition continues to change. They will also be educated regarding reviewing the resident Kardex before going on shift & providing care to a resident & ensuring all resident care plans are followed Education has been initiated by the Director of Health & Wellness to all Third Party Providers about third party charting and making DHW aware of all refusals **·How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place** To ensure all new admits are accurately assessed prior to move in. The Director of Health & Wellness will contact case	

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	illness including no pressure ulcers. He required his medications to be administered by staff; skin wounds were not managed independently or by 3rd party provider and he did not require staff assistance for dressing changes to wounds. Resident F had no 3rd party provider services or home health services. The MAR, dated May 2024, indicated on 5/12/24, wound care orders were changed to Mepilex border to be applied to the right heel and coccyx 2 times per week on Tuesday and Friday. Review of Resident F's record hadn't indicated the resident's wounds had been assessed and monitored. The record hadn't indicated the home health agency had responded or been to the facility to evaluate and care for the resident's wounds. The May 2024 MAR indicated, by nurse initials, the Mepilex dressing to the resident's heel and coccyx were being changed as ordered by facility staff. On 5/22/24 at 10:50 A.M., the Administrator was interviewed. She indicated Resident F had refused home health for treatment of his wound but was unable to find documentation of this. When questioned about who the wound care team was as referenced by the NP note on 5/1/24, the Administrator indicated it was facility staff who reviewed resident's care needs and who the NP was referencing. She contacted the Health and Wellness Director, who was on vacation but available by phone. The Health and Wellness Director confirmed the resident had refused home health for treatment of his wounds but didn't know where it had been documented. The Administrator indicated she would contact the home health agency and request records if available.		manager to ensure that there has not been a change in condition or readmit to hospital. If change has occurred, The Director of Health & Wellness will go onsite to reassess the current condition. Executive Director will follow up on all new admissions to ensure current assessment is appropriate for Assisted living The newly initiated tracking sheets will be monitored by the Director of Health & Wellness daily for three weeks, weekly for three weeks then monthly for four months. Findings suggestive of compliance will result in cessation for monitoring **·By what date will the systemic changes be completed** 6/30/2024	

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	On 5/22/24 at 3:15 P.M., the Administrator indicated she had contacted the home health agency. The agency had been out to see the resident on 5/17/24 and would fax over a copy of the visit. She indicated the facility would have to discharge residents who required skilled nursing care on a routine basis if they weren't willing to have 3rd party providers in to assist with their care. On 5/22/24 at 3:32 P.M., the Administrator provided a copy of the home health agency report dated 5/17/24 at 4:00 p.m. The report indicated Resident F was seen for an unstageable pressure ulcer to his right heel. The wound to his right heel measured 3 cm (centimeters) by 4 cm. It was covered by a necrotic (dead) scab with surrounding tissue being black in color. The wound was cleansed with soap and water and bordered optifoam heel dressing applied. Wound care was to be performed 3 times per week. During the visit, the resident's family member indicated the resident had a wound on his sacral area as well as his right foot heel. Wound care was done to both areas. The home health nurse observed an area on the resident's right buttock which looked as if it might breakdown. The nurse from the facility indicated the area would need treatment and they would call the NP and request a treatment. The wound to Resident F's sacrum was covered with optifoam dressing as preventative. The note hadn't been clear if the resident had a wound to his sacrum, coccyx, or buttocks nor how many wounds the resident had. A current facility policy, titled "Discharge Criteria" provided by the Administrator on 5/22/24 at 10:50 A.M., stated: "The community will establish guidelines for discharge from the			

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	community. The discharge criteria will be in compliance with individual state regulatory guidelines and will vary by State and Community...Procedure: The community will routinely monitor the resident's condition to ensure that their needs can be safely met in the community, in accordance with community and regulatory guidelines...The following are grounds for discharge or transfer from the community...If the physician or an appropriate assessment agency determines that the resident requires a higher level of care. If the community determines that a resident's functional level has advanced or declined so that the resident's needs cannot be met in the the home...." This tag relates to Complaint IN00433605.			
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency Based on interview and record review, the facility failed to ensure an evaluation of a resident's individual needs was completed timely prior to admission for 1 of 3 residents reviewed (Resident F). Findings include: On 5/21/24 at 11:23 A.M., Resident F's record was reviewed. Diagnoses included diabetes, coronary artery disease, high blood pressure, and right heel wound. A face sheet indicated Resident F's admission date to the facility was 2/21/24 but move in date was 4/24/24. A pre-admission evaluation, dated 3/22/24, indicated the resident was independent with	R 0214	**·What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** b> All residents are required to have an accurate, complete and active assessment in the system prior to admission per company policy **·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** To ensure compliance per	06/30/2024

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	mobility and transfers. He had incontinence but was independent in managing it. He was independent with bathing, dressing, and grooming himself. He had no wounds and hadn't required home health services. A hospital note, dated 4/24/24 at 3:00 p.m., indicated the resident had been brought to the hospital and hospitalized. His family member indicated the resident had been residing at a skilled facility where the resident developed a pressure ulcer to his right heel. The resident was weak, non-compliant, agitated, and medically non-compliant. He was admitted for failure to thrive, debility, multiple pressure ulcers and right heel wound with decreased pulses. A doppler study to his right leg was completed and found to be abnormal with decreased blood flow to the heel. He was not a candidate for treatment due to heart and kidney disease. Post Discharge orders from the hospital indicated the resident needed referral to the wound clinic for treatment of the pressure ulcer on his heel. He needed referral to home health, physical and occupational therapies. He had a wound to his bottom requiring treatment twice daily and close monitoring. A nurse note, dated 4/24/24 at 4:15 p.m. indicated the resident had arrived to the facility with family. He required assistance of 2 for transfer from car to wheelchair. He was able to bear weight and ambulated with small steps. His speech was clear, he was alert and oriented. He had a pressure area to his right heel black in color with brown skin surrounding the wound. The family member reported the resident had an open wound on his back unable to be assessed at the time. He required staff to lift him with a gait belt to stand		company policy the Director of Health & Wellness will assess residents initially which is accurate for 30 days unless change in condition. Residents with change in condition are reassessed 24-48 from note of change. DHW is also responsible for ensuring appropriate documentation is in the medical record **·What measures will be put into place or systemic changes to occur to ensure that the deficient practice does not reoccur** Executive Director and Director of Health & Wellness reviewed company policy and discussed importance regarding timeliness of updating and accuracy of care plans. The Director of Health & Wellness initiated a system to track all residents with current level of cares and date of next assessment. This is the primary responsibility of the Director of Health & Wellness. **·How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place** The director of Health & Wellness will monitor tracking sheets daily for three weeks, every other day	

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	up and turn to sit in his recliner chair. On 5/22/24 at 2:48 P.M., the Administrator was interviewed. She indicated it was the facility's policy to evaluate a potential resident and their care needs by use of Level of Care Assessment to be completed within 30 days prior to admission to ensure the facility could meet the resident's needs. She was unable to locate an updated level of care assessment after 3/22/24. The Administrator indicated a level of care assessment should have been updated prior to admitting the resident as he had several changes and admitted to the facility from the hospital. Current facility policy's, titled "Resident Level of Care Assessment" and "Admission Criteria/Description of Service" was provided by the Administrator on 5/22/24 at 2:33 P.M., indicated the following: "Resident Level of Care Assessment...A resident shall have a documented initial assessment to determine level of care. Objective: Completed within 30 days prior to admission to determine what services will be provided to the resident. To determine community appropriateness for residence..." "Admission Criteria/Description of Service...The community will advise residents and/or designated persons that residents with higher level of care needs; including This tag relates to Complaint IN00433605, IN00433930, and IN00433998. 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance		for three weeks then weekly for four months. Findings suggestive of compliance will result in cessation for monitoring Tracking sheets/ upcoming resident assessments will be part of discussion during QCCI monthly meetings going forward **·By what date will the systemic changes be completed** 6/30/2024	
R 0216 Bldg. 00				

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	Based on observation, interview and record review, the facility failed to ensure service plans were developed based on assessed care needs for 2 of 3 residents reviewed (Resident F and Resident G). Findings include: 1. On 5/21/24 at 11:23 A.M., Resident F's record was reviewed. Diagnoses included diabetes, coronary artery disease, high blood pressure, and right heel wound. The resident admitted to the facility from the hospital on 4/24/24. Post Discharge orders from the hospital, dated 4/24/24, indicated the resident needed referral to the wound clinic for treatment of a pressure ulcer on his heel. He needed referral to home health, physical and occupational therapies. He had a wound to his bottom requiring treatment twice daily and close monitoring. A Service Plan, dated 5/9/24, indicated Resident F had no behaviors, refusals or non-compliance with care. He had chronic health issues not managed and followed by a physician. He had no acute illness including no pressure ulcers. He required his medications to be administered by staff; skin wounds were not managed independently or by a 3rd party provider and he did not require staff assistance for dressing changes to wounds. Resident F had no 3rd party provider services or home health services. A nurse note, dated 4/24/24 at 4:15 p.m. indicated Resident F had arrived at the facility with family. He had a pressure area to his right heel, black in color with brown skin surrounding the wound. The family member reported the resident had an open wound on his back unable to be assessed at	R 0216	**·What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** All resident care plans have been reviewed by the Director of Health & Wellness to ensure that there is a current, accurate and signed care plan in the system and also in resident record to show compliance **·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected; no other residents were identified as being negatively impacted **·What measures will be put into place or systemic changes to occur to ensure that the deficient practice does not reoccur** Assessment tracking sheet has been initiated to reflect resident, date and next assessment date to ensure 100 % compliance **·How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place**	06/30/2024

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	the time. An NP (Nurse Practitioner) note, dated 5/1/24, indicated the resident was visited for chronic health issues. He had been refusing his blood pressure medications, had muscle weakness and decreased mobility. The resident had a deep tissue injury (DTI) to his right heel being managed by the wound care team. Assessment and Plan: High blood pressure: staff were to continue with his blood pressure medications and were to encourage him to take his scheduled doses. Right heel DTI: resident was to keep pressure off of heels at all times; staff were to monitor for worsening and the wound care team would continue to follow. Nurse Notes, dated 4/24/24 to 5/21/24 indicated the following: -4/25/24 at 5:00 a.m., resident was aggressive and argumentative with staff and wouldn't follow directions with assistance to stand and transfer. At 6:00 p.m., the resident activated his call light several times requesting staff to pull up his blanket closer to his face and assistance to elevate the head of his recliner despite the chair controller being within his reach. He was encouraged to do as much for himself as possible. -4/26/24 at 9:00 p.m., the resident refused to ambulate with assistance to the dining room or bathroom. He continued to ask staff to do tasks for him which he could do for himself. -4/30/24 at 7:00 a.m., resident was found to have an open area to his coccyx. He was educated on need to take pressure off the area. The NP was to evaluate the wound on 5/1/24. He continued to refuse his blood pressure medication and aspirin daily. -5/1/24 at 1:00 p.m., the NP visited the resident. He		The Director of Health & Wellness or designee will review all new admissions weekly x 4 weeks, then biweekly x 2 months then monthly x 3 months **·By what date will the systemic changes be completed** 6/30/2024	

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	was rude, argumentative and not willing to accept the NP's recommendations. -5/3/24 at 1:00 p.m., the resident refused his shower at 9:00 a.m. He was re-approached by the nurse and was asked to shower prior to having his bandages to his wounds changed. He refused. -5/9/24 at 12:00 p.m., the resident complained of a "sinus headache" and he wanted to see a doctor immediately. He indicated he needed antibiotics. The resident's family member was contacted, they indicated his facial pain was chronic, and had been evaluated by a neurologist who determined the pain was due to nerve damage from a previous root canal. The resident continued to believe when he had the pain, he should get an antibiotic to fix it and would ask for one. The family member indicated he was on pain medication for the pain and the family would bring to the facility. Resident F's service plan hadn't indicated the resident had behaviors related to refusals of care. The service plan hadn't indicated the resident had wounds, required treatment from a 3rd party provider, or facility staff would have to provide wound care. The plan hadn't indicated the resident refused medications and care assistance. The plan hadn't indicated the resident had a chronic health condition of facial nerve pain, required use of pain medication and need for education not to use antibiotics to treat. 2. On 5/22/24 at 10:57 A.M., Resident G and her spouse, both identified as interviewable by the facility, were interviewed in his room. Resident G's spouse indicated he'd recently been hospitalized due to a medication error. The error had affected his heart rate and blood pressure. Resident G appeared surprised and indicated she hadn't known why the resident had been hospitalized because she hadn't been told. She indicated her			

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	spouse remained very fatigued, wanted to sleep much, and had a poor appetite. She indicated she was glad it had been a medication error vs his overall health declining. On 5/22/24 at 11:20 A.M., LPN 5 (Licensed Practical Nurse) was interviewed. When questioned, she indicated Resident G's family hadn't wanted the resident to know about the medication error because she had a history of being overly focused and anxious about her spouses health. LPN 5 indicated she wasn't aware of where this information would be kept but was aware of it because family had shared it with her. On 5/22/24 at 1:54 P.M., Resident G's record was reviewed. Diagnoses included high blood pressure, breast cancer and dementia. She was admitted to the facility on 1/30/24. An undated pre-admission evaluation indicated the resident was independent with mobility, transfers, eating, bathing, dressing/grooming and toileting. She had no behaviors. She had a diagnoses of dementia and was prescribed psychotropics of anti-psychotic and anti-depressant medications. A Service plan, dated 2/29/24, indicated the resident was oriented to person, place and time. She had no behavioral issues, no agitation, anxiety, hallucinations, delusions, depression, nor altered sleep cycle. She was able to communicate independently. She was independent with activities of daily living and had chronic health care issues that included insomnia. She required staff to administer her medications and used no 3rd party provider services. Neither Resident G's pre-admission evaluation nor			

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	service plan indicated she had anxiety related to her spouse's health and conditions. There was no documentation in the resident's written record to indicate health information regarding her spouse was to be kept from her. On 5/22/24 at 2:48 P.M., the Administrator was interviewed. She indicated she hadn't known Resident G's family hadn't told her about the medication error or family wanted information about his health withheld from her due to her anxiety. She indicated this information should be part of the resident's service plan. A current facility policy, titled "Care Plan" was provided on 5/22/24 at 2:51 P.M. by the Administrator who indicated "Care Plan" was the same as "Service Plan". The policy stated: "Every resident that moves into Discovery Senior Living is required to have a care plan. The team will develop for each resident an individualized, comprehensive care plan that outlines the care the resident will be receiving. The Health and Wellness Director or designated nurse will complete an initial resident assessment prior to resident placement...A brief admission plan will be developed to include any obvious care required, based on assessment, observations and interviews with resident and family upon admission...A comprehensive plan will be developed to update the brief plan plus any added needs based on observations made during the first 30 days...Specific approaches and steps required for the resident will be included in the service plan...." This tag relates to Complaints IN00433605, IN00433930, and IN00433998.			

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R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on observation, interview and record review, the facility failed to ensure medication was administered to Resident E and insulin or pain medication was administered to Resident F in accordance with the physicians' orders for 2 of 2 residents reviewed for mediction administration. This deficient practice resulted in Resident E receiving six medications that were prescribed for another resident, requiring emergent care and hospitalization for low blood pressure.(Resident E and Resident F). Findings include: 1. On 5/22/24 at 11:37 A.M., Resident E's record was reviewed. Diagnoses included congestive heart failure, coronary heart disease, right bundle branch block (condition in which there's a delay or blockage along the pathway electrical impulses travel to make the heartbeat), and dementia. Resident E did not have a diagnosis of hypertension. A Service Plan, dated 2/29/24, indicated the resident required staff administration of medications up to 3 times per day with more than 4 medications per pass. A Nurse Practitioner (NP) progress note, dated 4/16/24, indicated Resident E was visited for care of chronic conditions. Vital signs were: blood pressure-118/56 and heart rate 78 beats per minute (bpm). No changes were made to the medications or plan of care. A nurse progress note, dated 5/3/24 at 7:10 a.m., indicated the resident had been administered	R 0241	**·What corrective actions will be accompanied for those residents found to have been affected by the deficient practice** Upon administration of scheduled medications, Licensed Nurse will use identifiers to ensure that the correct resident is given the correct medication **·How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents that receive medication from nurse have the potential to be affected. Nurse will ask name and date of birth. Resident name also written on the med cup containing the pills to ensure this does not reoccur **·What measures will be put into place or systemic changes to occur to ensure that the deficient practice does not reoccur** Individual nurse was educated on error and issued a note to file memo. On 5/30/2024 the Director of Health & Wellness initiated education on Medication Errors, proper med pass guidelines.	06/30/2024

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	another resident's medications, not prescribed to Resident E. Vital signs were taken, the note indicated the resident's blood pressure was 94/50 (normal parameter 120/80) and heart rate was 35 bpm (normal 60-100 bpm). The resident was sent to the Emergency Room (ER) for evaluation and treatment. A Triage note by the on-call NP, dated 5/3/24, indicated a medication error had occurred. The resident was given another's medication. The medication given included Norvasc 5 mg and Metoprolol Tartrate 100 mg (medications to lower blood pressure), escitalopram 20 mg (an anti-depressant medication), Metformin 500 mg (diabetic pill), omeprazole 20 mg (stomach pill), and oxybutinin 5 mg (medication for bladder incontinence). The resident's blood pressure was low (94/50, normal is 120/80) and he was sent to the hospital for treatment. A review of current physician's order summary indicated Resident E was not prescribed Norvasc, Metoprolol Tartrate, escitalopram, Metformin, omeprazole, or oxybutinin. A hospital discharge summary, dated 5/8/24, indicated the resident had been hospitalized from 5/3/24-5/8/24 related to a medication error. On 5/21/24 at 2:15 P.M., LPN 5 (Licensed Practice Nurse) was interviewed. She indicated, on 5/3/24 at 7:10 a.m., Resident E came around the corner to enter the dining room and stopped to chat with her while she was preparing another resident's medications. She then approached Resident E at the dining room table and gave him the other resident's medication who sat at his table. She realized she had given the resident the wrong medications, immediately checked for allergies to		technique and procedures to be followed when administering medication to all facility LPN's and QMA's. This education will be completed by 6/15/2024. Any staff not completing education will not be allowed to work until it has been completed. This education will also be added to the new hire orientation checklist Director of Health & Wellness will ensure that all residents receive medications as ordered by the physician and re administer Medication administration competencies for all licensed LPN's and QMA's **·How the corrective actions will be monitored to ensure that the deficient practices will not reoccur-What quality assurance program will be put into place** Medication Administration performance will be monitored by the Director of Health & Wellness weekly for four weeks, biweekly for 4 weeks then monthly for 4 months to ensure 100% compliance The Director of Health & Wellness will conduct med pass audits on each nurse. These audits will be conducted randomly over the next 6 months. All findings of concern will be immediately addressed and discussed at monthly safety committee meetings	

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	the medications given, then notified the Director of Health and Wellness who instructed her to obtain vitals immediately and monitor every 15 minutes. Initial vitals were obtained, showed a lower than normal blood pressure and low heart rate. The NP was notified and the resident was sent out to the hospital. On 5/22/24 at 10:57 A.M., Resident E and his spouse were interviewed in his room. He indicated he had been given the wrong medication, the nurse told him right away and checked his vital signs. He felt worse for the nurse as she had been very upset at having made the error. He then ended up at the hospital for a few days. His spouse indicated he remained very fatigued since returning to the facility and seemed to just want to sleep. She indicated his appetite was poor and he seemed too tired to even eat. During an observation on 5/22/24 at 10:57 A.M., Resident E's face was pale, and closed his eyes off and on during the interview. A Medication Administration Record (MAR) dated May 2024, indicated the resident's pulse was monitored daily since his return to the facility on 5/8/24. His pulse continued to run low with the lowest being 34 bpm and the highest being 44 bpm. The resident was to have a follow up appointment with the cardiologist. Information for Metoprolol Tartrate and Norvasc was obtained on 5/22/24 from drugs.com . The article titled Metroprolol Tartrate indicated the medication was a Beta blocker, and could cause the heart to not pump as hard making it difficult to pump blood out to the body which could cause or worsen heart failure. Persons with heart block who are given Metoprolol, could cause the heart block		**·By what date will the systemic changes be completed** 6/30/2024	

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	to worsen or the heart to stop beating. Adverse reactions/side effects included tiredness, low blood pressure, and low heart rate. The article, titled Norvasc, indicated the medication is a calcium channel blocker, could cause hypotension (low blood pressure). The use of both medications together caused a moderate interaction by reducing the heart rate, heart nerve conduction, and heart contractibility (heart pump). While the combination of the 2 medications may be useful and effective in some situations, potentially serious cardiovascular adverse effects such as congestive heart failure, severe hypotension, and/or angina (chest pain) may occur. 2. On 5/21/24 at 11:23 A.M., Resident F's record was reviewed. Diagnoses included diabetes, coronary artery disease, and high blood pressure. No diagnosis was listed related to facial pain. 2a. A facility incident, reported to the Indiana Department of Health on 4/29/24 at 1:35 p.m., indicated a medication error had occurred for Resident F on 4/27/24 at 8:37 p.m. The report indicated the resident had been administered his supper dose of insulin instead of his bedtime dose. Preventative measures to prevent recurrence were to review facility medication administration policies and educate staff on the rights of safe medication administration to ensure resident safety. A Service Plan, dated 5/9/24, indicated the resident required staff to administer insulin, assist with blood sugar monitoring, administer routine and as needed medications. The April 2024 Physician Orders indicated Resident F should receive 5 units of Humulin R (a short-acting insulin) for a bedtime blood sugar			

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	measurement of 389 mg/dl on 4/24/24. The April and May 2024 physician orders did not include documentation to indicate Resident F should receive Humalog (a fast-acting insulin) at bedtime, but indicated Humalog should be administered with Humulin R in accordance with the sliding scale order at mealtimes as follows: -141-180 mg/dl (miligrams/deciliters)-give 2 units of Humulin R -181-220 mg/dl -give 3 units of Humulin R -221-260 mg/dl -give 4 units of Humulin R -261-300 mg/dl -give 6 units of Humulin R Over 300 mg/dl -give 8 units of Humulin R and call the physician. The April 2024 Medication Administration Record (MAR) indicated Resident F was administered 8 units of Humulin R for a bedtime blood sugar measurement of 389 mg/dl on 4/24/24. The April 2024 MAR indicated Humalog was not administered with Humulin R at mealtimes in accordance with the physician orders on 15 of 18 opportunities between 4/25/24 and 4/30/24 as follows: -4/25/24 at 11:00 a.m. blood sugar (BS) was 250 mg/dl. Resident was administered 4 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=327 mg/dl; administered 8 units of Humulin R insulin but should have received 10 units. -4/26/24 at 7:00 a.m. BS=178 mg/dl; administered 0 units of Humulin R insulin but should have received 4 units. 11:00 a.m. There was no documented administration of insulin on the MAR which was left blank. 4:00 p.m. BS=252 mg/dl; administered 4			

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	units of Humulin R insulin but should have received 8 units. -4/27/24 at 7:00 a.m. BS=187 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=229 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=267 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. -4/28/24 at 7:00 a.m. BS=178 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=234 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=196 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. -4/29/24 at 7:00 a.m. BS=187 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=320 mg/dl; administered 8 units of Humulin R insulin but should have received 10 units. 4:00 p.m. BS=198 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. -4/30/24 at 7:00 a.m. BS=204 mg/dl; administered 3 units of Humulin R insulin but should have received 6 units. The April 2024 MAR indicated 8 units of Humalog was administered nightly for six nights without a physician's order between 4/25/24 and 4/30/24. The May 2024 MAR indicated Humalog was not administered with Humulin R at mealtimes in accordance with the physician orders on 50 of 63			

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	opportunities between 5/01/24 and 5/21/24 as follows: -5/1/24 at 7:00 a.m. BS=204 mg/dl; administered 3 units of Humulin R insulin but should have received 6 units. 11:00 a.m. BS=223 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=217 mg/dl; administered 3 units of Humulin R insulin but should have received 6 units. -5/2/24 at 11:00 a.m. BS=238 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=260 mg/dl; administered 4 units of Humulin R insulin but should have received 8 units. -5/3/24 at 7:00 a.m. BS=181 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=268 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. 4:00 p.m. BS=260 mg/dl; administered 4 units of Humulin R insulin but should have received 8 units. -5/4/24 at 7:00 a.m. BS=199 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=244 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/5/24 at 11:00 a.m. BS=224 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/6/24 at 7:00 a.m. BS=152 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 4:00 p.m. BS=133 mg/dl; administered 0 units of Humulin R insulin but should have			

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	received 2 units. -5/7/24 at 7:00 a.m. BS=183 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=227 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=186 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. -5/8/24 at 7:00 a.m. BS=160 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=160 mg/dl administered 2 units of Humulin R insulin but should have received 4 units. 4:00 p.m. BS=135 mg/dl; administered 0 units of Humulin R insulin but should have received 2 units. -5/9/24 at 7:00 a.m. BS=192 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=233 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/10/24 at 11:00 a.m. BS=278 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. 4:00 p.m. BS=303 mg/dl; administered 6 units of Humulin R insulin but should have received 10 units. -5/11/24 at 7:00 a.m. BS=161 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 4:00 p.m. BS=234 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/12/24 at 7:00 a.m. BS=152 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units.			

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	11:00 a.m. BS=164 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. -5/13/24 at 7:00 a.m. BS=197 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=222 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=191 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. -5/14/24 at 7:00 a.m. BS=160 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=203 mg/dl; administered 3 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=243 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/15/24 at 7:00 a.m. BS=176 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=211 mg/dl; administered 3 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=231 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/16/24 at 7:00 a.m. BS=140 mg/dl; administered 0 units of Humulin R insulin but should have received 2 units. 11:00 a.m. BS=178 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 4:00 p.m. BS=232 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/17/24 at 7:00 a.m. BS=175 mg/dl; administered 2			

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	units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=212 mg/dl; administered 0 units of Humulin R insulin but should have received 6 units. 4:00 p.m. BS=230 mg/dl; administered 4 units of Humulin R insulin but should have received 6 units. -5/18/24 at 7:00 a.m. BS=200 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=293 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. 4:00 p.m. BS=260 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. -5/19/24 at 7:00 a.m. BS=170 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=287 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. 4:00 p.m. BS=297 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. -5/20/24 at 7:00 a.m. BS=205 mg/dl; administered 3 units of Humulin R insulin but should have received 6 units. 11:00 a.m. BS=267 mg/dl; administered 6 units of Humulin R insulin but should have received 8 units. 4:00 p.m. BS=192 mg/dl; administered 3 units of Humulin R insulin but should have received 4 units. -5/21/24 at 7:00 a.m. BS=162 mg/dl; administered 2 units of Humulin R insulin but should have received 4 units. 11:00 a.m. BS=238 mg/dl; administered 4 units of Humulin R insulin but should have			

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	received 6 units. The May 2024 MAR indicated 8 units of Humalog was administered nightly for 20 nights without a physician's order between 5/01/24 and 5/20/24. 2b. A Service Plan, dated 5/9/24, did not indicate the resident required staff to administer routine and as needed medications. No pain assessment was available for review. On 5/22/24 at 10:22 A.M., Resident F was interviewed. His affect was flat and his face pale. He indicated he was having much pain in his face and staff wouldn't give him pain medications. He indicated he was only able to have the medication every 8 hours and the medication wasn't helping his pain. When asked if he'd spoken to his doctor, he was adamant he had to do what he was told by the staff and there was nothing he could do about it. He indicated prior to admission at the facility, he would take Tramadol 4 times per day when having the facial pain which was due to a nerve injury from dental work. A review of current physicina's order summary did not indicate Tramadol had been ordered for Resident F. A nurse note, dated 5/9/24 at 12:00 p.m., indicated Resident F complained of a sinus headache. He hadn't appeared in distress but demanded staff get him a doctor immediately. The resident's family was contacted who reported the resident had recurring facial pain, evaluated by a neurologist and believed to be due to nerve damage from a previous root canal. The family member indicated the resident had taken Tramadol (an opiod medication for moderate to severe pain) routinely for the pain when he was at home. The family			

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		A. BUILDING 00 B. WING	05/22/2024

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	member was going to bring in the prescription Tramadol. The NP was notified and had approved. A MAR, dated May 2024, indicated an undated order for Tramadol 50 milligram (mg) tablets; take 1 tablet by mouth daily 3 times per day for pain. The Tramadol was not given 3 times per day as ordered. The medication was given on the following days and times: -5/10/24 at 1:00 a.m. -5/11/24 at 7:30 a.m. and 5:30 p.m. -5/12/24 at 7:00 a.m. and 3:30 p.m. -5/13/24 at 7:00 a.m. and documented as non-effective. -5/14/24 at 7:00 a.m. and documented as non-effective. -5/15/24 at 7:00 a.m. and 4:20 p.m. -5/16/24 at 7:00 a.m. -5/17/24 at 8:00 a.m. and 5:00 p.m. -5/18/24 at 12:20 a.m. and 7:15 a.m. -5/19/24 at 7:15 a.m. -5/20/24 at 7:00 a.m. -5/21/24 at 7:00 a.m. The record indicated Tramadol was not administered in accordance with the physician's order for 19 of 36 opportunities between 5/10/24 and 5/21/24. On 5/22/24 at 2:48 P.M., the Administrator was interviewed. She indicated she hadn't been made aware of Resident F's facial pain but would address it immediately. Regarding the medication errors, she indicated staff were to be re-educated on medication administration policies; however, due to scheduling conflicts, the training had not yet been completed but was scheduled for May 30, 2024 at 1:00 p.m. On 5/22/24 at 2:51 p.m., the Administrator			

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	provided a current copy of the facility policy titled "Medication Administration" which stated the following: "The community will provide resident with assistance, as needed, with medication prescribed for self-administration. Medication not prescribed for self-administration must be administered by a licensed physician, nurse, or certified med-technician...Medication administration includes the following activities, based on the needs of the resident: Identify the correct resident...." A policy regarding medication errors was requested but not provided by staff. The policy did not indicate any information about the 5 rights of medication administration. This tag relates to Complaints IN00433605, IN00433930, and IN00433998.			