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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COVENTRY MEADOWS, L.L.C.	7833 W JEFFERSON BLVD FORT WAYNE, IN 46804

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R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00434079. Complaint IN00434079 - State deficiencies related to the allegations are cited at R0064. Survey date: May 24, 2024. Facility number: 005846 Residential Census: 77 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed May 24, 2024	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance Based on interview and record review the facility failed to ensure residents were free of misappropriation of medication for 2 of 3 residents reviewed (Resident C, Resident D). Findings include: During an interview on 5/24/24 at 10:11 AM, the Excetive Director (ED) indicated Licensed Practical Nurse (LPN) 3 had reported a medication allegation towards Qualified Medication Aide (QMA) 2. LPN 3 had indicated QMA 2 had administered PRN medications to Resident C and Resident D more often than any other staff. The ED indicated she had reviewed the April and May narcotic sheets and then the video footage. The ED indicated she had observed QMA 2 sign	R 0064	What corrective action(s) will be accomplished for those Residents found to have been affected by the deficient practice? Employee was immediately suspended following allegation/incident and employment terminated following investigation. 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 additional	06/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Owens	Executive Director	06/14/2024

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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	narcotic medication out, then took the medication himself in the nurses station area. The ED indicated she had interviewed QMA 2, who denied the accusation at first, but then admitted to taking an allergy pill and stomach acid reducer from 2 other residents. An investigation file was provided by the ED on 5/24/24 at 10:17 AM. The file included the following: A facility reported incident, dated 5/6/24, indicated QMA 2 was alleged of signing out narcotics but did not administer the medications to the prescribed residents. The file included a timeline of events, which indicated the following: On 5/6/24 at 11 AM, LPN 3 notified the ED of a narcotic medication trend with Resident C, Resident D and QMA 2. LPN 3 indicated Resident C and Resident D's narcotic sheets indicated PRN (as needed) medication was signed out more often when QMA 2 worked. The ED reviewed the narcotic sheets for Resident C. The narcotic sheet indicated a routine order and a PRN order and was given the following dates by QMA 2. 4/27/24 - Norco (hydrocodone - acetaminophen pain medication) was given 4 times. 5/5/24 - Norco was given 5 times. The ED reviewed the narcotic sheets for Resident D. The narcotic sheet indicated a routine order and a PRN order and was given the following dates by QMA 2. 4/27/24 - tramadol (opioid) was given 4 times. 5/5/24 - tramadol as given 5 times.		Residents reported or identified during investigation. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur? All staff will be re-educated by 6/15/2024 on Resident Rights and abuse policies, including but not limited to misappropriation. Staff qualified to administer medications will also be re-educated on medication administration policy including PRN narcotics. New hires receive education on Resident Rights and abuse policy on orientation. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All staff will be re-educated by 6/15/2024 on Resident Rights and abuse policies, including but not limited to misappropriation. Staff qualified to administer medications will also be re-educated on medication administration policy including PRN narcotics. New hires receive education on Resident Rights and abuse policy on orientation. Abuse policy CQI tool will be used weekly x 4 weeks then monthly x 3 months. If 100% threshold not met, disciplinary	

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	The ED, Director of Nursing (DON), and Human Resources (HR) reviewed the video footage dated 5/5/24, which indicated: At 6:45 AM, QMA 2 was observed pulling medications from the narcotic drawer of the medication cart and placed the medication in medication cups. QMA 2 emptied the medication into his hand. QMA 2 was then observed walking to the nursing station, looked around, put the pills in his mouth, returned to the medication cart and took a drink form his bottle. At 1:07 PM, QMA 2 was observed rummaging through the second drawer of the medication cart, obtained a prescription bottle, dumped the medication into a medication cup and walked to the nurses station. QMA 2 sat the medication cup down on the counter, sat down and took the medication that was in the cup. The investigation file included statements, indicated the following: LPN 3's statement, dated 5/6/24, indicated she had noticed QMA 2 had been consistently signing out extra 2-3 PRN Norco medications for Resident C. LPN 3 also indicated she had noticed QMA 2 had consistently been signing out an extra 2 PRN tramadol every day QMA 2 worked. LPN 3 indicated QMA 2 was the only medication passer who signed out the PRN medications and hardly documented on the Medication Administration Record (MAR). QMA 2's statement, dated 5/7/24, indicated on Sunday he arrived for his shift, started his routine narcotic count and started to pull the medications for administration. QMA 2 indicated he sat the		action and new action plan will be completed. The monitoring tool will be completed by Executive Director/designee. Monitoring tools and results will be reviewed at least monthly in WeCare meetings for 10 months.	

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	pills aside, obtained an allergy relief medication from a drawer and later consumed a stomach acid reduction pill from another drawer. QMA 2 indicated he did not take any other medications. Scheduler 5's statement, dated 5/6/24, indicated she watched the video footage, dated 5/5/24 at 6:45 AM. Scheduler 5 indicated she observed QMA 2 pull narcotics out of the narcotic box, put the pills in a cup, tipped the pills into his hand and walked to the nurses station. Scheduler 5 indicated the video footage observed QMA 2 consume the pills from the cup at the nurses station. Scheduler 5 indicated at 1:07 PM the same day, QMA 2 was observed in the video, took pills from the second drawer and placed the pills in a pill cup. QMA 2 was then observed taking the pill cup to the nurses station, sat it down, sat down himself and then put the pills in his mouth. The Business Office Manager (BOM)'s statement, dated 5/6/24, indicated she had reviewed the video footage, dated 5/5/24. The BOM indicated she had observed "QMA 2 at the medication cart around 6:45 AM, fidgety and looked extremely nervous." The BOM indicated QMA 2 put some medication in medication cups and then dump the pills into his hand. QMA 2 is then observed looking around and walked to the nurses station, put the pills in his mouth and then walked back to the medication cart and took a drink. BOM indicated at 1:07 PM QMA 2 was observed in the video "at the medication cart, put some pills into a medication cup, took them to the nurses station and clearly popped them into his mouth." ED's statement, dated 5/7/24, indicated she interviewed QMA 2 regarding the allegations. ED indicated when QMA 2 arrived to discuss the allegations and concerns, QMA 2 had indicated "I			

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	just want to go home." The ED explained the severity of the allegations and QMA 2 then stated "just so you know I always give Resident C and Resident D their PRN narcotics." The ED indicated in her statement that at the time, the ED had not mentioned anything about the medications or residents in question. QMA 2 indicated he took an allergy pill and stomach pill from 2 residents. 1. A record review was completed for Resident B on 5/24/24 at 10:58 AM. Diagnosis included dementia, anxiety and chronic pain. An order dated, 3/3/24 - 5/6/24, indicated to give Resident B hydrocodone - acetaminophen (Norco) 5-325 mg tablet, 1 tablet by mouth 2 times a day and 1 tablet by mouth every 6 hours PRN. The Narcotic sheet, dated April 2024, indicated QMA 2 signed out 5 total tablets of Norco on 4/27/24. The MAR and nursing notes, dated 4/27/24, did not indicate PRN Norco was administered on 4/27/24 to Resident B. The 3 doses were unaccounted for on the MAR. The Narcotic sheet, dated May 2024, indicated QMA 2 signed out 5 total tablets of Norco on 5/5/24. The MAR and nursing notes, dated 5/5/24, did not indicate PRN Norco was administered on 5/5/24. The 3 doses were unaccounted for on the MAR. 2. A record review was completed for Resident C on 5/24/24 at 11:18 AM. Diagnsois included Alziehmer's disease, scoliosis and hypertension.			

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	An order, dated 1/18/24 - 5/6/24, indicated to take 1 -50 mg tablet of tramadol three times a day and 1 tablet every 8 hours PRN. The Narcotic sheet, dated April 2024, indicated QMA 2 signed out 4 tramadol on 4/27/24. The MAR and nursing notes, dated 4/27/24 did not indicate PRN tramadol was administered on 4/27/24. The 1 dose was unaccounted for on the MAR. The Narcotic sheet, dated May 2024, indicated QMA 2 signed out 5 tramadol on 5/5/24. The MAR and nursing notes, dated 5/5/24 did not indicate PRN tramadol was administered on 5/5/24. Therefore, the 2 doses were unaccounted for on the MAR. During an interview on 5/24/24 at 10:51 AM, LPN 4 indicated a QMA was required to request permission from a nurse to administer PRN narcotics. LPN 4 indicated the nurse completed a pain assessment in the resident's record when a PRN was administered. A policy, undated, titled "General Dose Preparation and Medication Administration," was provided by the ED on 5/24/24 at 12:19 PM. The policy indicated "authorized personnel, as determined by Applicable Law, assist with administration or observation of medication according to times of administration as determined by the community. " This citation relates to Complaint IN00434079.			