STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155716	A. BUILDING 00 B. WING	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411714 and IN00413277. This visit included the Investigation of Residential Complaint IN00412600 Complaint IN00413277 - No deficiencies related to the allegations are cited. Complaint IN00411714 - Federal/State deficiencies related to the allegations are cited at F684, F658, and F9999. Survey dates: 7/18/23-7/20/23 Facility number: 000439 Provider number: 155716 AIM number: 100275070 Census Bed Type: SNF/NF: 98 SNF: 11 Residential: 12 Total: 121 Census Payor Type: Medicare: 10 Medicaid: 81 Other: 18 Total: 109 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on July 28, 2023.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance citedduring the Complaint Survey and complaint survey conducted July 20, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 18, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
F 0658 SS=D	483.21(b)(3)(i) Services Provided Meet Professional			

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	Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. Based on observation, interview, and record review, the facility failed to administer medications as ordered by the physician for 1 of 4 residents (Resident B) observed during medication pass. Finding includes: During a random medication administration observation on 7/19/23 at 7:12 A.M., Licensed Practical Nurse (LPN) 5 administered 3 pills to resident B. Two of the medications administered by LPN 5 to Resident B included 1 tablet of Morphine Sulfate extended release (ER) 60 milligram (mg) and 1 tablet of Morphine Sulfate ER 15 mg, which equaled 75 mg total. Resident B's record was reviewed on 7/19/23 at 10:35 A.M. Diagnoses included, but were not limited to, lung cancer, malnutrition, and pelvis fracture. Resident B's most recent admission Minimum Data Set (MDS), dated 7/3/23, indicated the resident was cognitively intact and required extensive assistance of two for mobility and toileting. Resident B's physician order, dated 6/27/23, indicated Morphine Sulfate ER Oral Capsule Extended Release 24 Hour 80 MG Give 1 capsule by mouth two times a day for pain management. During an interview on 7/19/23 at 12:13 P.M., LPN 5 indicated 1 tablet of Morphine Sulfate 60 mg and	F 0658	**F658** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Order clarification was received for Resident B. Medications administered per order. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents with medication orders have the potential to be affected. No other residents were identified. Medications administered per order. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The facility policy for Medication Administration was reviewed and found to be appropriate. Nurses and QMAs will be in-serviced on the Five Rights of Medication Administration and steps to take if there is a discrepancy between	08/18/2023

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	1 tablet of Morphine Sulfate 15 mg had been administered in place of the physician's order of 1 capsule of Morphine Sulfate 80 mg because the correct medication was not available at the time in the medication cart. A current facility policy, titled "Medication Administration and General Guidelines", dated 2020, was received from the Administrator on 7/20/23 at 9:30 A.M. indicated "Medications are administered in accordance with written orders of the attending physicians." "If the label and the MAR are different...facility personnel will contact (name of Pharmacy) if any discrepancies are noted." This Federal tag relates to Complaint IN00411714. 3.1-35(g)(1)		the medication received and the order. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DON or designee will complete an audit to determine if the medications administered match the physician's orders. Audits will be completed on 10 residents twice a week for four weeks, then 10 residents weekly for four weeks, then 10 residents monthly for four months. Audits will continue for at least six months and until 100% compliance is achieved for 3 consecutive months. Results of all audits will be reviewed by the IDT in QA and adjustments to the correction will be made if indicated. **By what date the systemic changes for each deficiency will be completed:** August 18, 2023	
F 0684 SS=G Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with			

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	professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview, and record review, the facility failed to ensure a resident was provided medication as ordered, notification of medication change to family, and notification of medication ordered between specialty physicians and primary physicians, resulting in loss of blood flow to right lower leg, and ischemia due to clots in the lower extremities for 1 of 3 residents (Resident D) reviewed for quality of care. Findings include: The clinical record was reviewed for Resident D on 7/19/23 at 6:51 A.M. Diagnoses included, but were not limited to, presence of cardiac pacemaker, atrial flutter, atrial fibrillation, and long term use of anticoagulants. A significant change Minimum Data Set (MDS) assessment, dated 2/6/23, indicated Resident D was severely cognitively impaired and required extensive assistance of two for mobility, transfers, dressing, and toileting. A care plan, dated 9/12/18 through 2/24/23, included, but was not limited to, interventions as follows: I would like staff to continue to keep me and my family updated on my care, and I have a pacemaker; Give all cardiac meds as ordered by the physician, observe side effects and report adverse reactions to physician. On 10/30/22 at 12:15 P.M., a progress note indicated family was in the facility and gave concern for bruising noted. The progress note indicated family was told the Nurse Practitioner	F 0684	**F684** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident D has been discharged; therefore, a correction of past actions cannot be completed. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** Residents who receive medications, have medication changes, and/or have multiple practitioners participating in care have the potential to be affected. No other residents were identified. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The policy and procedure labeled Resident Change of Condition was reviewed and found to be appropriate. An in-service will be completed with nurses and QMAs regarding medication administration per orders, family and physician notification regarding medication changes, and documentation of such. An	08/18/2023

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	would see the resident the following day, and the family would be updated afterwards. A Nurse Practitioner (NP) progress note, dated 10/31/22 at 10:24 A.M., indicated resident D was seen for new areas of bruising. The NP gave orders to discontinue the resident's anticoagulant medication and check complete blood count (CBC) and levels. On 11/1/22 at 11:19 A.M., labs were resulted and sent to the facility; the hemoglobin and platelet levels were both noted in normal range. On 12/1/22 1:08 P.M., a progress noted Resident D had returned from a cardiologist appointment, and orders were given to continue Eliquis. The clinical record and care conference dated 12/8/22 lacked notification to family regarding the discontinuation of Eliquis (anticoagulant). During a review of physician orders, the record indicated Eliquis was discontinued on 10/31/22 and lacked any further Eliquis orders past that date. A Nurse Practitioner note, dated 1/11/23, indicated Resident D was seen for right great toe pain. An order was given for Keflex (antibiotic) and Miconazole cream (antifungual cream) to feet for 14 days. A NP note, dated 1/19/23 at 1:26 P.M., indicated an X-ray for the right foot was ordered and resulted normal findings. A hydrocodone (pain medication) order was renewed. A NP note, dated 1/27/23 at 8:45 A.M., indicated Resident D was seen for swelling and redness in the right foot. No new orders given.		in-service will be completed for the IDT on reviewing new orders and the required documentation in the clinical meeting. All new orders will be reviewed five times a week in a clinical meeting for any changes in medications, and a review of documentation completed to determine if family and participating physicians have been notified. Notification will be made to the family and/or participating physicians if not already completed by the nurse receiving the initial order. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** An audit will be completed by DON or designee to determine if medications are administered per order, and family/ physicians have been notified. Audits will be completed on 10 residents twice a week for four weeks, then 10 residents weekly for four weeks, then 10 residents monthly for four months. Audits will continue for at least six months and until 100% compliance is achieved for 3 consecutive months. Results of all audits will be reviewed by the IDT in QA and adjustments to the correction will be made if indicated.	

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	A NP note, dated 1/30/23 at 11:49 A.M., indicated Resident D was seen for increased pain in the right foot and purple tinged toes. An order was given to check venous and arterial blood flow. A radiology report, dated 1/30/23 at 2:36 P.M., indicated an ultrasound of the right lower extremity was performed. Clinical information noted included pain and swelling, purple in color of the 1st, 2nd, and 3rd toes, open non-healing wound of the right great toe, and breakdown of skin and weeping. Findings of the right lower arterial ultrasound included no flow detected below the right common femoral artery, and clot within the distal superficial femoral artery and popliteal artery. The resident was then transferred from the facility to the hospital for evaluation. A hospital progress note, dated 1/30/23 at 9:47 P.M., indicated Resident D was seen in the emergency room and was referred for a vascular surgery consult. During the vascular surgery consult, a confirmation of occlusion of Resident D's right superficial femoral and popliteal arteries was indicated. The plan of care stated the physician explained to Resident D's family acute limb ischemia required emergency intervention but would not be a good surgical candidate and this may be an end of life situation. Resident D was admitted on hospice services on 2/1/23 and expired on 2/23/23. During an interview on 7/20/23 at 10:40 A.M., the Nurse Practitioner indicated that heart related medication orders given by Cardiology supersede orders given by facility nurse practitioners, and indicated the orders given on 12/1/22 by Resident D's cardiology that the resident should continue		**By what date the systemic changes for each deficiency will be completed:** August 18, 2023	

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	on Eliquis were not given to the NP by the facility. The NP stated that communication between the facility, such as when a resident receives orders from an outside physician, would be logged in the NP communication binders located at the nurse's station. During an interview on 7/19/23 at 12:03 P.M., a copy of the NP communication log from December 2022 was requested. The Administrator stated the facility does not keep these logs longer than one month in medical records and was unable to provide a copy of the NP communication log or verify if the facility NP or physician was made aware of the medication notification. On 7/20/23 at 9:30 A.M., the Administrator provided a current copy of the policy and procedure labeled Resident Change of Condition, dated 8/2022. The policy indicated all changes will be communicated to the physician and family/responsible party. This Federal tag relates to Complaint IN00411714. 3.1-37(a)			
F 9999 Bldg. 00	3.1-13 ADMINISTRATION AND MANAGEMENT (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy in the administrator's position. The requirement was NOT MET as evidenced by: Based on interview and record review, the facility	F 9999	**F9999** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The change of administrator form was submitted to the Indiana Department of Health.	08/18/2023

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R 0000	failed to notify the Indiana Department of Health of a change in administrator within three working days. Finding includes: On 7/18/23 at 3:42 P.M., the Administrator indicated the previous administrator left the position on 6/30/23 and she took over on 7/1/23. She indicated she emailed the notice to the Indiana Department of Health (IDOH) on 7/3/23 when she gained access to the computer system. On 7/18/23 at 3:50 P.M., the Administrator or Director of Nursing Change form was provided by the Administrator showing the last date of the previous administrator and the appointment date of the new administrator. The form lacked confirmation and date of submission to IDOH. On 7/19/23 at 6:50 A.M., the Administrator indicated she was unable to locate the email showing she sent the form to IDOH. She further indicated she never received confirmation of receipt from IDOH. On 7/20/23 at 9:30 A.M., the Administrator indicated the facility policy for notification of Administration change was to follow the State regulation. This Federal tag related to Complaint IN00411714.		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents were affected by the practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of HR was educated on the need for the submission of Change of Administrator form and how to ensure that it is accepted by IDOH. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** If there is a change in administrator, the Director of HR will complete an audit to determine if the form is completed in a timely manner. A copy of the audit will be reviewed in QA. **By what date the systemic changes for each deficiency will be completed:** August 18, 2023	

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Bldg. 00	This visit was for the Investigation of Residential Complaint IN00412600. This visit included the Investigation of Nursing Home Complaint IN00411714 and IN00413277 Complaint IN00412600- State deficiencies related to the allegations are cited at R088, R214, R216, and R298. Survey dates: 7/18/23-7/20/23 Facility number: 000439 Residential Census: 12 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance citedduring the Complaint Survey and complaint survey conducted July 20, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 18, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	
R 0088 Bldg. 00	410 IAC 16.2-5-1.3(c)(1-2)(d)(1-2) Administration and Management - Noncompliance c) The licensee shall: (1) appoint an administrator with either a: (A) comprehensive care facility administrator license as required by IC 25-19-1-5(c); or (B) residential care facility administrator license as required by IC 25-19-1-5(d); and (2) delegate to that administrator the authority to organize and implement the day-to-day operations of the facility. (d) The licensee shall notify the director: (1) within three (3) working days of a vacancy			

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	in the administrator's position; and (2) of the name and license number of the replacement administrator Based on interview and record review, the facility failed to notify the Indiana State Department of Health of a change in administrator within three working days. Finding includes: On 7/18/23 at 3:42 P.M., the Administrator indicated the previous administrator left the position on 6/30/23 and she took over on 7/1/23. She indicated she emailed the notice to the Indiana Department of Health (IDOH) on 7/3/23 when she gained access to the computer system. On 7/18/23 at 3:50 P.M., the Administrator or Director of Nursing Change form was provided by the Administrator showing the last date of the previous administrator and the appointment date of the new administrator. The form lacked confirmation or date of submission to IDOH. On 7/19/23 at 6:50 A.M., the Administrator indicated she was unable to locate the email showing she sent the form to IDOH. She further indicated she never received confirmation of receipt from IDOH. On 7/20/23 at 9:30 A.M., the Administrator indicated the facility policy for notification of Administration change was to follow the State regulation. This Residential State Finding relates to Complaint IN00412600.	R 0088	**R088** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The change of administrator form was submitted to the Indiana Department of Health. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** No residents were affected by the practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Director of HR was educated on the need for the submission of Change of Administrator form and how to ensure that it is accepted by IDOH. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** If there is a change in administrator, the Director of HR	08/18/2023

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			will complete an audit to determine if the form is completed in a timely manner. A copy of the audit will be reviewed in QA. **By what date the systemic changes for each deficiency will be completed:** August 18, 2023	
R 0214 Bldg. 00	410 IAC 16.2-5-2(a) Evaluation - Deficiency (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on interview and record review, the facility failed to ensure semiannual evaluations were completed for 2 of 4 residents reviewed for semiannual evaluations. (Resident M, Resident N) Findings include: 1. On 7/19/23 at 7:54 A.M., Resident M's clinical record was reviewed. Resident M was admitted on 10/1/21. The record lacked a semiannual evaluation after 10/14/22. 2. On 7/19/23 at 8:33 A.M., Resident N's clinical record was reviewed. Resident N was admitted on 9/15/18. The record lacked a semiannual evaluation after 10/28/22. On 7/19/23 at 11:07 A.M., the Administrator indicated semiannual evaluations should be	R 0214	**R214** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The semiannual evaluation was completed for Resident M and Resident N. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** An audit was completed to review the last date of completion for semiannual evaluations for residents in the residential portion of the facility. Any evaluations	08/18/2023

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	updated every 6 months. On 7/20/23 at 9:35 A.M., a current Resident Assessment policy, revised 8/2022, indicated "assessments are to be performed at the time of admission...and/or as observed or deemed necessary". At that time, the Administrator indicated there was no policy specific to residential and the provided policy applied to the entire facility. This Residential State Finding relates to Complaint IN00412600.		due were completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Social Services, DNS, ADNS, and MDS were educated on the requirement for semi-annual evaluation. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will complete an audit monthly for six months on all residents on the residential unit to ensure that the semiannual evaluations have been completed. Results of the audits will be reviewed in QA monthly for at least six months and until 100% compliance achieved for three consecutive months and adjustments to the correction will be made if indicated. **By what date the systemic changes for each deficiency will be completed:** August 18, 2023	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs			

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	155716	A. BUILDING 00 B. WING	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF EVANSVILLE	601 N BOEKE RD EVANSVILLE, IN 47711

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	assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on observation, interview, and record review, the facility failed to ensure residents that were self administering medications were assessed for capability to self administer medications for 2 of 2 residents observed for medication administration. (Resident M, Resident N) Findings include: 1. On 7/19/23 at 6:58 A.M., LPN (Licensed Practical Nurse) 3 was observed to administer medications for Resident M in the residential dining room. Medications prepared for administration included, but were not limited to, 1 furosemide 40 mg (milligrams) tablet, 1 metoprolol 25 mg tablet, 1 acetaminophen 650 mg tablet, 1 calcitriol .25 mcg (micrograms) capsule, 1 losartan 50 mg tablet, and 1 Rene-vite 1 mg tablet. LPN 3 handed Resident M the medications in a medication cup and left the dining room before the resident took the medications. On 7/19/23 at 7:54 A.M., Resident M's clinical record was reviewed. Diagnosis included, but was not limited to, dementia. The most recent service plan, dated 4/14/23, indicated the resident required health care professionals to administer injections,	R 0216	**R216** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** The semiannual evaluation was completed for Resident M and Resident N. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken:** An audit was completed to review the last date of completion for semiannual evaluations for residents in the residential portion of the facility. Any evaluations due were completed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Social Services, DNS, ADNS, and MDS were educated on the requirement for semi-annual	08/18/2023

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	pills or liquids and required complete supervision and administration of all medications. The most recent semi annual evaluation, dated 10/14/22, indicated staff should administer all medications. Current physician orders included, but was not limited to: Furosemide 40 mg - give 1 tablet by mouth two times a day for hypertension, dated 11/11/22 Metoprolol tartrate 25 mg - give 25 mg by mouth two times a day for hypertension, dated 12/15/22 Acetaminophen ER 650 mg - give 650 mg by mouth two times a day for pain management, dated 10/23/22 Calcitriol 0.25 mcg - give 1 capsule by mouth one time a day for chronic kidney disease, stage 4, dated 5/26/22 Losartan Potassium 25 mg - give 1 tablet by mouth one time a day for hypertension, dated 10/27/22 Rene-vite Rx 1 mg - give 1 tablet by mouth one time a day for chronic kidney disease, stage 4, dated 10/30/22 The clinical record lacked an order for self administration of medications. 2. On 7/19/23 at 7:15 A.M., LPN 3 was observed to administer medications for Resident N in the residential dining room. Medications prepared for administration included, but were not limited to, 1 TBSP (tablespoon) Miralax and 1 TBSP Metamucil mixed in 8 oz (ounces) of water, 1 multivitamin tablet, 1 calcium-vitamin D3 600 mg tablet, and 1 docusate sodium 100 mg capsule. LPN 3 handed Resident N the medications in a medication cup and left the dining room before the resident took the mediations. On 7/19/23 at 8:33 A.M., Resident N's clinical record was reviewed. Diagnosis included, but was		evaluation. Nurses and QMAs were educated on self-administration of medication based on resident evaluations and orders. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The Executive Director or designee will complete an audit monthly for six months on all residents on the residential unit to ensure that the semiannual evaluations have been completed. The DNS or designee will complete an audit monthly for six months on residents on the residential unit to determine if medications are being administered based on the evaluation of ability to self-administer. Results of the audits will be reviewed in QA monthly for at least six months and 100% compliance for at least three consecutive months and adjustments to the correction will be made if indicated. **By what date the systemic changes for each deficiency will be completed:** August 18, 2023	

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	not limited to, mild cognitive impairment. The most recent service plan, dated 4/28/23, indicated the resident required health care professionals to administer injections, pills or liquids and required complete supervision and administration of all medications. The most recent semi annual evaluation, dated 10/28/22, indicated staff should administer all medications. Current physician orders included, but was not limited to: Miralax powder - give 1 tbsp by mouth one time a day for constipation mixed in 8 ounces of liquid, dated 5/27/21 Metamucil fiber packet - give 1 scoop by mouth one time a day for fiber, dated 5/27/21 Multivitamin - give 1 tablet by mouth one time a day for supplement, dated 5/27/21 Calcium-vitamin D3 600-200 mg - give 1 tablet by mouth two times a day for supplement, dated 10/13/21 Docusate Sodium 100 mg - give 1 capsule by mouth one time a day every Wednesday, Sunday for constipation, dated 5/19/21 The clinical record lacked an order for self administration of medications. On 7/19/23 at 11:07 A.M., the Administrator indicated that a resident needed an evaluation and physician order to self administer medications. She further indicated the nurse should follow the service plan for residents living in the residential apartments. On 7/20/23 at 9:35 A.M., a current Self-Administration of Medications policy, revised December 2016, indicated "the staff and practitioner will assess each resident's mental and physical abilities to determine whether			

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	self-administering medications is clinically appropriate for the resident. If the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications". This Residential State Finding relates to Complaint IN00412600.			
R 0298 Bldg. 00	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on interview and record review, the facility failed to ensure drug regimen reviews were completed every 60 days for 4 of 4 residents reviewed for medications. (Resident K, Resident L, Resident M, Resident N) Findings include: 1. On 7/18/23 at 3:09 P.M., Resident K's clinical record was reviewed. Resident K was admitted on 1/10/23. The record lacked a drug regimen review after 2/25/23.	R 0298	R298 **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** A pharmacist evaluation was completed for Resident K, Resident L, Resident M, and Resident N. **How other residents having the potential to be affected by the same deficient practice will be**	08/18/2023

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	2. On 7/19/23 at 7:54 A.M., Resident M's clinical record was reviewed. Resident M was admitted on 10/1/21. The record lacked a drug regimen review after 2/25/23. 3. On 7/19/23 at 8:33 A.M., Resident N's clinical record was reviewed. Resident N was admitted on 9/15/18. The record lacked a drug regimen review after 2/25/23. 4. On 7/19/23 at 9:00 A.M., Resident L's clinical record was reviewed. Resident L was admitted on 11/26/22. The record lacked a drug regimen review after 2/25/23. On 7/19/23 at 11:07 A.M., the Administrator indicated the medication regimen reviews should be completed by the pharmacy once a month. On 7/20/23 at 9:35 A.M., a current Medication Regimen Reviews policy, revised May 2019, indicated "medication regimen reviews are done upon admission ... and at least monthly thereafter, or more frequently if indicated". This Residential State Finding relates to Complaint IN00412600.		**identified and what corrective action will be taken:** All residents in residential have the potential to be affected. A pharmacist review was completed for all residents in the residential unit. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** Medication Regimen Reviews policy was reviewed and determined to be appropriate. Communication was initiated with pharmacy to ensure that the consulting pharmacist had access to the residential charts and was aware of the need for review. DNS and ADNS were educated on the requirements for pharmacy review. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** DNS or designee will audit all residents in the residential unit monthly for six months to determine that the pharmacy review was completed. Results of the audit will be reviewed in QA for at least six months and until 100% compliance for at least three consecutive months and adjustments to the correction will be made if indicated.	

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			By what date the systemic changes for each deficiency will be completed: August 18, 2023	