STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155825	A. BUILDING 00 B. WING	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: July 5, 6, 7, 10 and 11, 2023 Facility number: 000389 Provider number: 155825 AIM number: 100288920 Census Bed Type: SNF/NF: 23 Residential: 17 Total: 40 Census Payor Type: Medicare: 1 Medicaid: 19 Other: 3 Total: 23 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on July 14, 2023.	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. St. Augustine Home for the Aged desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective August 10, 2023. We respectfully request a desk review of our Plan of Correction.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven M. Still, MPA	Administrator	07/28/2023

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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	the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate an allegation and immediately take action to prevent further abuse or mistreatment from occurring while the investigation was in progress for 1 of 1 resident reviewed regarding abuse or mistreatment. (Resident 10) Finding includes: The record for Resident 10 was reviewed on 07/07/2023 at 2:21 p.m. Diagnoses included, but were not limited to, dementia with mood disturbance, anxiety disorder, major depressive disorder, total retinal detachment affecting the right eye, general muscle weakness, unsteadiness on feet, and repeated falls. A current MDS (Minimum Data Set) assessment, dated 05/30/2023, indicated the resident had a BIMs (Brief Interview for Mental Status) score of 9, indicating the resident demonstrated a cognitive impairment. A progress note, dated 02/19/2023 at 7:00 p.m., indicated "Late Entry...Writer spoke to Resident in regard to her complaint of left wrist pain. There was noticeable redness on her left small finger and knuckle area. When she was asked what happened, she stated, "a staff member pulled her	F 0610	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** As stated in CMS-2567, CNA 13 resigned her position on 2/23/23 and is no longer employed by this facility. No other residents were raised concerns about care given by staff before or after the date of this incident, including CNA 13. All staff in-service training was conducted on April 28, 2023 addressing the recognition, reporting and prevention of resident abuse. (See Exhibit F610-D, training syllabus and attendance record) An additional all-staff training on Abuse recognition, reporting and prevention is scheduled for August 11, 2023. (See Exhibit F640-B, in-service posting) All new employees are educated on abuse recognition, reporting and prevention before starting work on the unit. (See Exhibit F610-C, orientation syllabus)	08/10/2023

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	very roughly and hurt her wrist". There is no evidence of swelling, redness or swelling on her wrist..." An "Incident Report to the Indiana State Department of Health," dated 02/19/2023 and provided by the Administrator on 07/10/2023 at 2:31 p.m., indicated on 02/19/2023, "Administrator notified this evening that (Resident 10) alleged the woman in the 'yellow hat' was rough with her. (Resident 10) claimed her wrist was sore". The type of injury to the resident was described as "...her left wrist was sore. No swelling or visible marks noted. Some redness noted to her left pinkie finger". Preventative measures were identified as "There is a staff member that wears a head covering and was assigned to the resident's care. Staff member was sent home pending the outcome of our investigation". The identity of the CNA believed to be involved was revealed by the HRD (Human Resources Director) during an interview on 07/10/2023 at 2:42 p.m. CNA 13 had worked at the facility since 06/09/2015 and according to the HRD had been a loyal employee with no complaints of her care to residents during her employment. The HRD indicated CNA 13 was sent home on the evening of 02/19/2023 and resigned her position on 02/23/2023. The actual working hours of CNA 13 was requested and received from Clinical Nurse 12 on 07/10/2023 at 9:22 a.m. According to the timesheets, CNA 13 worked a double shift, clocking in on 02/18/2023 at 2:45 p.m., and clocking out 02/19/2023 at 7:10 a.m. The CNA returned to the facility again on 02/19/2023 at 2:20 p.m., to work her normal evening shift. The CNA was observed to have clocked out at 9:25 p.m.,		**How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** All residents have the potential to be affected by this practice. In the future, if any allegation of abuse is reported per facility policy, the Administrator and other designated members of the facility's leadership will be notified. An investigation will be initiated which will include resident and staff interviews. Staff involved or named in the allegation will be immediately suspended from work until the investigation is completed. Social Services will follow up with the resident(s) involved to assess for any mental or psychosocial distress. Mental health services will be provided if necessary. The Administrator will report the incident and the findings of the investigation to IDOH per state requirements. All staff in-service training was conducted on April 28, 2023 addressing the recognition, reporting and prevention of resident abuse. (See Exhibit F610-D, training syllabus and attendance record) An additional all-staff training on Abuse recognition, reporting and prevention is scheduled for August 11, 2023. (See Exhibit F610-B, Training Syllabus) All new employees are educated	

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	when she was directed to leave the facility pending the investigation. A review of the facility's investigation of the allegation, received from the facility Administrator on 07/10/2023 at 2:31 p.m., contained a typed, unidentified statement, which the facility indicated was a statement from dayshift LPN 4. This statement indicated "This morning (Resident 10) reported to me (LPN) that 'the CNA with a yellow band on her head twisted my hand when getting me up to use the bathroom'. When asked when this happened (Resident 10) replied 'at 3 in the morning'...Res (resident's) left wrist slightly red in color. No other signs of abuse seen at that time." During an interview, on 07/11/2023 at 11:25 a.m., Clinical Nurse 12 indicated Sister 1 was informed of the allegation "sometime in the morning of 02/19/2023" by LPN 4, but she was unaware of the exact time. Sister 1 indicated she would "take care of it" and documented the note in Resident 10's clinical record as a "late entry" at 7:00 p.m., the same day. During an interview, on 07/11/2023 at 2:12 p.m., Sister 1 indicated she had written the late entry in the progress notes, dated 02/19/2023 at 7:00 p.m., however she was unable to recall the time she initially had been notified of Resident 10's allegation on the morning of 02/19/2023. Sister 1 was unable to remember when or who originally informed her of the allegation. When asked the name of the unidentified LPN who authored the unidentified statement contained in the investigation materials, she indicated she was unable to recall. No reason was given when asked why CNA 13 was allowed to return to work on the evening shift of 02/19/2023.		on abuse recognition, reporting and prevention before starting work on the unit. (See Exhibit F610-C, orientation syllabus) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Facility leadership will review the process followed for abuse and other related investigations. This review will be conducted in the QAPI meeting scheduled for 7/27/2023. At that meeting, the Administrator and Mother Superior will in-service facility leadership on the process of a thorough investigation to include the interviews of other residents having the potential to be affected by the alleged practice. (See Exhibit F610-A & A1 Abuse Investigation Protocol and Attendance Record). Quarterly in-servicing for all staff on abuse recognition, reporting and prevention with be conducted for the next 180 days. Annual in-servicing for all staff will resume thereafter. **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.** Abuse investigations will be reviewed in the QAPI meetings.	

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	The overall facility investigation lacked documentation including interviews with other residents living around or on the same unit as Resident 10 and CNA 13 was allowed to return to the facility on 02/19/2023 to care for residents until the CNA was sent home from the facility at 9:25 p.m. A current policy, titled "Abuse, Neglect and Exploitation," received from the Administrator on 07/11/2023 at 2:27 p.m., indicated "It is the policy of this home to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit abuse, neglect, exploitation and misappropriation of resident property...Investigation of alleged abuse, neglect and exploitation...An immediate investigation is warranted when suspicion of abuse, neglect or exploitation or reports of abuse, neglect or exploitation occur...Protection of Resident...The home will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: Responding immediately to protect the alleged victim and integrity of the investigation...room or staffing, if necessary, to protect the resident(s) from the alleged perpetrator...." 3.1-28(d)		Administrator and Mother Superior will lead the review. QAPI currently meets monthly. **By what date the systemic changes for each deficiency will be complete.** August 10, 2023	
F 0637 SS=D Bldg. 00	483.20(b)(2)(ii) Comprehensive Assessment After Signifcant Chg §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a			

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	"significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) Based on record review and interview, the facility failed to ensure a significant change Minimum Data Set (MDS) assessment was completed for a resident with a fall resulting in injury, left sided weakness, and increased behavioral issues for 1 of 3 residents reviewed for MDS assessments. (Resident 7) Finding includes: The record for Resident 7 was reviewed on 07/07/23 at 10:26 a.m. Diagnoses included, but were not limited to, cerebral infarction (stroke), dementia, and repeated falls. A nursing progress note, dated 5/16/22 at 1:22 a.m., indicated the resident fell resulting in an injury on the back and a raised area on the back of the head. The initial neurological checks were within normal limits. A physician's progress note, dated 5/16/23 at 10:15 a.m., indicated the spouse noticed differences in the resident's neurological status and was concerned. The facility called 911 for further evaluation. A progress note, dated 5/23/23 at 5:10 p.m., indicated the resident was re-admitted into the facility and the MD (Medical Doctor) was notified of the return.	F 0637	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** On July 7, 2023 the MDS Coordinator scheduled Resident 7 for a significant change assessment. The assessment was completed on July 18, 2023. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by this practice. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** On June 16, 2023, the facility hired a new MDS Coordinator with over fifteen (15) years of experience in managing a large Medicare/Medicaid caseload. Additionally, our MDS Consultant visits monthly to review MDS	08/10/2023

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	A progress note, dated 5/24/23 at 10:30 a.m., indicated the resident was making sexual comments to staff members. A physician's note, dated 5/26/23 at 10:00 a.m., indicated the resident returned from the hospital which determined the diagnoses of a stroke which resulted in left sided weakness and encephalopathy (altered mental status). A physician's note, dated 6/20/23 at 10:00 a.m., indicated care for the resident had been complicated due to inappropriate statements and new actions of sexual nature such as grabbing staff members. The resident had residual left sided hemiparesis (weakness). During an interview, on 07/10/23 at 11:54 a.m., the MDS Coordinator indicated the resident should have had a significant change MDS assessment completed after the resident had declines in more than one area of the health including left sided weakness and increased behavioral issues. A current policy, titled "CHANGE IN RESIDENT CONDITION OR STATUS," dated as revised on 08/2018 and received from DON (Director of Nursing) on 7/11/23 at 1:40 p.m., indicated " ...The MDS Coordinator is to be notified (ASAP) of any physical or mental changes in a Resident so that the need for a Significant Change MDS may be determined...." 3.1-31(d)(1)		management as we transition from the previous MDS Coordinator. On July 26, 2023, the MDS Coordinator and MDS Consultant conducted an in-service for the IDT on recognizing, reporting and scheduling MDS significant change assessments. (See Exhibit F637-A, Significant Change Inservice Training Syllabus and Record of Attendance). The in-service was conducted for the Inter-disciplinary care team (IDT). **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 plac**e. The MDS consultant will conduct weekly audits of significant changes for four (4) weeks and then monthly for three (3) months. (See Exhibit F637-B Audit Tool). The MDS consultant will provide written reports to the Administrator, DON and Mother Superior for review. **By what date the systemic changes for each deficiency will be complete.** August 10, 2023	
F 0727 SS=D Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON §483.35(b) Registered nurse §483.35(b)(1) Except when waived under			

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	paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. Based on interview and record review, the facility failed to ensure a Registered Nurse was in the facility for 8 hours during a 24-hour period for 9 days of the first quarter of 2023 reviewed for sufficient staffing. (2/4, 2/5, 2/18, 2/19, 2/25, 2/26 and 3/5, 3/11, 3/19) Finding includes: A Payroll-Based Journal (PBJ) Staffing report, for the first quarter of 2023, indicated the facility failed to have Registered Nurse coverage for 02/4, 2/5, 2/18, 2/19, 2/25, 2/26, 3/5, 3/11, and 3/19. During a record review, on 07/11/2023 at 10:19 a.m., the actual worked staffing schedules indicated there was no RN coverage for 02/4, 2/5, 2/18, 2/19, 2/25,2/26, 3/5, 3/11, and 3/19. During an interview, on 07/07/23 at 11:56 a.m., the Facility Scheduler indicated the PBJ staffing showed there was no RN staffing coverage for 6 days in February and 3 days in March. She would have to get with the Human Resources Director to verify if the information on the PBJ was correct.	F 0727	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** There were no residents identified in the survey finding as being directly affected by this practice. It should be noted that as of June 16th, which is prior to this survey, there have been no days that have been without eight (8) consecutive hours of RN coverage. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** No other residents have the potential to be directly affected by this practice. **What measures will be put into place and what systemic changes will be made to**	08/10/2023

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	During an interview, on 07/07/2023 at 3:41 p.m., the Human Resources Director indicated they did not have RN coverage on the weekends in February and March due to nursing shortage. She indicated the reporting on the PBJ Staffing report was correct. She confirmed the dates with no RN scheduled or worked were 02/4, 2/5, 2/18, 2/19, 2/25,2/26, 3/5, 3/11, and 3/19. She was aware there needed to be RN coverage every day for 8 consecutive hours a day. She indicated the issue was discussed with the Leadership Team and the Facility Scheduler. During an interview, on 07/10/2023 at 11:45 a.m., the Human Resource Director indicated herself and the Administrator were not aware of the RN staffing issues until after the dates had happened. A current policy, titled "RN Administrative Rotation," dated 06/2023 and received from Human Resources Director on 07/11/23 at 10:00 a.m., indicated "...To ensure there is a minimum of 8 hours of Registered Nurse (RN) coverage on the weekends and holidays. The administrative RN staff shall rotate the responsibility of ensuring there is proper RN coverage of at least 8 hours per day on Saturdays, Sundays, and Holidays. The RN on duty shall have in his/her possession a designated work phone from the end of the business day on Friday to the beginning of the business day on Monday and on assigned holidays. In the event that there are less than 8 RN hours scheduled on a Saturday, Sunday or Holiday, the RN on duty will be required to report to work for an 8-hour shift. The RN may replace another workday in the same pay period with this shift if his/her job duties permit. The scheduler will make every attempt to schedule a minimum of 8 hours RN coverage. In the event of call off on a Saturday, Sunday, or Holiday resulting in fewer		**ensure that the deficient practice does not recur?** Since February 2023, the facility has hired five (5) registered nurses. This includes a new Director of Nursing, an MDS Coordinator (RN) and three (3) RNs to serve on the unit. Since June 2023, the policy "RN Administrative Rotation" has been reviewed and renamed to reflect the facility's process more accurately for addressing the challenge of maintaining RN coverage. (See Exhibit F727-A RN Coverage). The facility has been successful in meeting the requirement for RN coverage every day since that time. Additionally, the facility has a weekly meeting of the Recruitment/Retention committee where staffing needs are reviewed and strategies are discussed towards resolution. The Scheduling Coordinator is responsible for the creation and maintenance of the nursing schedule, including RN coverage. If the schedule has changed and there is no RN coverage for a particular day, the Scheduling Coordinator will contact the Director of Nursing and coordinate RN coverage with her. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality**	

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	than 8 hours of RN coverage, the Scheduler shall make every effort to replace the call off with another RN. Should RN coverage not be found, the RN on duty shall report to work for a minimum of 8 hours..." 3.1-17(b)(3)		**assurance program will be put into place.** The results of scheduling RN coverage will be reviewed at the monthly QAPI meeting. If any recommendations are made, the Administrator and DON will follow up and report the status of the recommendations at the next scheduled QAPI meeting. **By what date the systemic changes for each deficiency will be complete.** August 10, 2023	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all			

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	aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Based on observation, interview and record review, the facility failed to ensure medications were disposed of according to regulations and standards of practice for 1 of 5 residents reviewed for medication observation. (Resident 21) Findings include: During a medication observation, on 07/07/23 at 9:48 a.m., LPN 10 prepared the following medications for Resident 21: furosemide (a medication used to decrease fluid in the body) 20 mg (milligrams), acetaminophen (a mild pain medication) 500 mg, prednisone (a steroid) 5 mg, apixaban (a blood thinner) 2 mg, amiodarone HCL (used for an irregular heartbeat) 200 mg and mixed with pudding. The resident refused the medications due to nausea. The nurse took the medication into the soiled utility room and flushed them down the hopper (a flushing rim sink used for disposal of blood or body fluids) (e.g., bedpan washing). During an interview, on 07/07/23 at 10:00 a.m., LPN 10 indicated she had disposed of them in the hopper before. During an interview, on 07/10/23 at 11:30 a.m., LPN	F 0755	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 21 was not put at risk by the practice as the refused medication was destroyed timely and away from, and not requiring an interaction with the resident. The Medication Disposal Policy has been reviewed and updated. Each nurse has been given the policy for their review. Once reviewed, each nurse signed the policy, and it has been placed in the employees' file. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by this practice. In-servicing will be conducted for	08/10/2023

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	155825	A. BUILDING 00 B. WING	07/11/2023

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	4 indicated she disposed of refused medications in the biohazard needle container. During an interview, on 07/11/23 at 10:55 a.m., the Director of Nursing indicated the facility did not have a policy for drug destruction and did not know where the logs were kept for destruction. She was not aware if the staff logged the medications which had been destroyed. During an interview, on 07/11/23 at 11:08 a.m., Clinical Nurse 3 brought policies for medication disposal and indicated the Drug Buster (a liquid used to dispose of medications) should have been used to dispose of the medications. During an interview, on 07/11/23 at 11:27 a.m., Clinical Nurse 12 indicated she would destroy medications in the Drug Buster. She indicated LPN 10 should have disposed of the medications in the Drug Buster. A current policy, titled "Discontinued Medications," dated as reviewed on 5/16/19 and received from the Clinical Nurse on 07/11/23 at 11:00 a.m., "...discontinued medications not returned to the pharmacy are destroyed in accordance with the Medication Destruction Policy...if in question please refer to State and Federal laws regarding medication disposal...." 3.1-25(o)		all nurses and QMAs. The in-servicing will address the facility drug destruction policy and procedure. (See Exhibit F755-A Disposal of Medications). In-service to be conducted by the Staff Development Coordinator. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Staff Development Coordinator or Clinic Nurse will visit on each shift to interview nurses and QMAs regarding their knowledge of the facility policy for disposal of medications. They will document the interview results and any re-training that was done for incorrect answers on the Medication Disposal Policy Review Rounds form. These interviews will be done at least weekly for the next 60 days. **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.** Results of the Medication Disposal Policy interviews will be brought to the QAPI meeting at least monthly, for the next 60 days, for review and recommendations by the QAPI committee. If any	

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			recommendations are made, the DON, Staff Development Coordinator, or Clinic Nurse will follow up as assigned and report the results of those recommendations at the next monthly meeting. **By what date the systemic changes for each deficiency will be complete.** August 10, 2023	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: July 5, 6, 7, 10 and 11, 2023 Facility number: 000389 Residential Census: 17 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on July 14, 2023.	R 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. St. Augustine Home for the Aged desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective August 10, 2023. We respectfully request a desk review of our Plan of Correction.	
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are			

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	present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to destroy controlled substances after a medication was discontinued and to dispose of a compromised controlled substances for 1 of 1 medication cart reviewed for medication storage. (West cart) Finding includes: During an observation, on 7/5/23 at 11:54 a.m., the West cart on the second floor had a card of Hydrocodone-Acetaminophen (a controlled pain medication) 5-325 mg (milligrams) for Resident 2. The number 13 slot on the back of the card was exposed and clear tape covered the pill. The record for Resident 2 was reviewed on 7/5/23 at 1:37 p.m. Diagnoses included, but were not limited to, hypertension, depressive disorder, anxiety disorder, atrial fibrillation, and pain. A physician's order, dated 11/14/22, indicated to give two tablets of hydrocodone-acetaminophen (pain medication) 5 mg (milligram) every 4 hours as needed. A physician's order, dated 2/8/23, indicated to discontinue the hydrocodone-acetaminophen 5 mg every 4 hours as needed. During an interview, on 7/5/23 at 1:05 p.m., QMA 2 indicated she did not know why the tape was on the back and she did not know the policy for destroying medication.	R 0304	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 2 was not put at risk by the practice as the discontinued medication was stored in the medication cart and did not require an interaction with the resident. The Medication Disposal Policy has been reviewed and updated. Each nurse has been given the policy for their review. Once reviewed, each nurse signed the policy, and it has been placed in the employees' file. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents have the potential to be affected by the practice. In-servicing will be conducted for all nurses and QMAs. The in-servicing will address the facility drug destruction policy and procedure. (See Exhibit R304-A Disposal of Medications). In-service to be conducted by the Staff Development Coordinator. A	08/10/2023

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	During an interview, on 7/5/23 at 1:15 p.m., Clinical Nurse 3 did not know the policy on taping the back of a medication card and would look for the policy. During an interview, on 7/5/23 at 3:50 p.m., the Director of Nursing would have to look up the policy on when narcotics were discontinued and left in the medication cart. During an interview, on 7/5/23 at 4:30 p.m., the Clinical Nurse 3 indicated the policy stated to destroy the taped narcotics and to destroy narcotics when they were discontinued. A current policy, titled "Controlled Medication Destruction," dated 5/16/19 and received by the Clinical Nurse on 7/5/23 at 2:48 a.m., indicated "...Medication included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations...Schedule II medications remaining in the facility after a resident has been discharged, or the order discontinued, are disposed of either in the facility by the administrator and/or director of nursing and/or consultant by returning to the Drug Enforcement Administration (DEA); or by retaining for destruction by an agent of the DEA, as directed by state laws, regulations, and/or the DEA...Schedule III, IV, and V controlled substances are disposed of at the facility by two licensed personnel, as directed by the state law...Controlled substances may not be returned to the pharmacy...." A current policy, titled "Medication Disposal," dated 8/2018 and received by the Clinical Nurse		complete medication cart audit is being conducted by the pharmacy the week of July 24th. Results of that audit will be given to the Administrator and DON for further follow up as needed. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Staff Development Coordinator or Clinic Nurse will visit on each shift to interview nurses and QMAs regarding their knowledge of the facility policy for disposal of medications. They will document the interview results and any re-training that was done for incorrect answers on the Medication Disposal Policy Review Rounds form. These interviews will be done at least weekly for the next 60 days. The pharmacy will conduct cart audits monthly for the next 60 days and will forward the monitoring results to the Administrator and DON. **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.** Results of the medication cart audits, and the Medication Disposal Policy interviews will be	

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	on 7/5/23 at 4:50 p.m., indicated "...When medications are discontinued they shall be removed from the Cottage by destruction. All expired medications and controlled substances shall be destroyed by destroyed by two licensed Nurses or by a nurse and Pharmacist...To ensure that discontinued medications, regardless of their route, do not remain either in the medication cart or the medication room...Discontinued medications are to be destroyed by two (2) Licensed Nurses. Note of destruction is made on the Individual Resident's Disposal of Medication Sheet as indicated and signed by both Nurses...."		brought to the QAPI meeting for review and recommendations by the QAPI committee members. If any recommendations are made, the DON, Staff Development Coordinator, or Clinic Nurse will follow up as assigned and report the results of those recommendations at the next monthly meeting. **By what date the systemic changes for each deficiency will be complete.** August 10, 2023	