STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 00 B. WING	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT RD INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: December 5, 6, 7, 8 and 11, 2023 Facility number: 000070 Provider number: 155149 AIM number: 100266190 Census Bed Type: SNF: 4 SNF/NF: 75 Total: 79 Census Payor Type: Medicare: 4 Medicaid: 60 Other: 15 Total: 79 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on December 20, 2023.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any confusion set forth in the statement of deficiencies or of any violation of the regulation. This provider request that the 2correction be considered the letter of credible allegation and request desk review (paper compliance) on or after 12/5/24	
F 0582 SS=D Bldg. 00	483.10(g)(17)(18)(i)-(v) Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;			

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

Scott Piotrowicz | Executive Director | 12/27/2023

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	(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the			

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	resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. Based on record review and interview, the facility failed to ensure there was documentation to show the resident/representative made the choice about the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) and to ensure the resident's financial representative was notified of the SNF ABN for 2 of 3 residents reviewed for beneficiary notification. (Resident 6 and 56) Findings include: 1. The SNF ABN for Resident 6 indicated the resident no longer required skilled nursing care and did not need skilled rehabilitation on a daily basis. Beginning on 11/19/23, the resident's stay would not be covered under Medicare. The options indicated the resident/representative was to check only one box and the facility could not choose a box for the resident/representative. Option 2 was checked to indicate the resident/representative wanted the care listed above and did not want Medicare billed. The resident/representative understood they may be billed now because they were responsible for the payment of the care. They could not appeal because Medicare would not be billed. The facility did not have documentation to show the resident/representative had chosen option 2 on the SNF ABN. 2. The SNF ABN for Resident 56 indicated the resident no longer required skilled nursing care and did not need skilled rehabilitation on a daily basis. Beginning on 11/23/23, the resident's stay	F 0582	1. It is the policy of the facility to notify residents/responsible party of ABN and the date skilled services will end. .Social Services in-serviced on documentation for ABN notification. There was a note placed in file for one resident and other resident has expired. One of residents is no longer here and other resident weas fixed. 2. . An audit will be performed for past two months notifications and all new notifications will have notes added to resident's chart by Social Services. 3. Executive Director or Designee will review in morning meeting up-coming ABN's with Social Services, to insure compliance. 4. Audits of the ABN documentation will be audited weekly by Executive Director or Designee for compliance using QAPI tool.. Findings will be reported to QAPI committee during monthly meeting. This will be on-going for six (6) months. If 100% not achieved and action plan will be initiated. 5. Completed 1/6/24	01/05/2024

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	would not be covered under Medicare. The options indicated the resident/representative was to check only one box and the facility could not choose a box for the resident/representative. Option 2 was checked to indicate the resident/representative wanted the care listed above and did not want Medicare billed. The resident/representative understood they may be billed now because they were responsible for the payment of the care. They could not appeal because Medicare would not be billed. The facility contacted Resident 56's healthcare representative by telephone and mailed the paperwork to the healthcare representative and did not include the resident's financial representative. The facility did not have documentation to show the resident/representative had chosen option 2 on the SNF ABN. During an interview, on 12/11/23 at 12:21 p.m., the Business Office Manager (BOM) indicated the SNF ABN should have been sent to the resident's financial representative. During an interview, on 12/11/23 at 12:23 p.m., the BOM indicated if the resident's representative would not come to the facility, then they would complete a phone call about the SNF ABN. The Social Services Director (SSD) would complete the phone call. During an interview, on 12/11/23 at 3:02 p.m., the SSD indicated she was not aware she would need to document or make a progress note about the conversation with the resident's representative about the option they chose for the SNF ABN form. She did not have any documentation to			

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	provide to show the option was chosen by the representative and not the facility. During an interview, on 12/11/23 at 4;19 p.m., the SSD indicated the facility did not have a policy on beneficiary notices. She was only verbally instructed by the facility on how to complete the process. 3.1-4(f)(3)			
F 0644 SS=D Bldg. 00	483.20(e)(1)(2) Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. Based on interview and record review, the facility failed to initiate a new PASARR (Preadmission Screening and Resident Review) level I when a resident was started on a new psychotropic medication for 2 of 2 residents reviewed for PASARR. (Resident 44 and 38)	F 0644	1 It is the policy of the facility to complete a Level 1 upon the resident change when the addition of an appropriate diagnosis and/or addition of defined medications would trigger a PASRR Level 2 to be completed. Both residents	01/05/2024

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	Findings include: 1. The record for Resident 44 was reviewed on 12/8/23 at 10:25 a.m. Diagnoses included, but were not limited to, dementia, major depression with agitation, bipolar disorder, and other personality and behavioral disorder. A PASARR level I, dated 4/18/2019, indicated the resident had one mental health diagnoses of personality change and was not taking any antipsychotic medications. A PASARR level II, dated 8/11/22, indicated the resident was added a bipolar diagnosis and was not taking any antipsychotic medications. A physician's order, with a start date of 9/2/22 and an end date of 9/21/23, indicated the resident took Olanzapine (an antipsychotic medication) 5 milligrams (mg) at bedtime. There was no new PASARR done after the resident was started on an antipsychotic medication. During an interview, on 12/8/23 at 2:06 p.m., the SSD (Social Service Director) indicated Resident 44 did not have a new PASARR completed after he was started on the antipsychotic medication. The resident should have had another PASARR. During an interview, on 12/11/23 at 5:16 p.m., the DON (Director of Nursing) indicated Resident 44 did not have a PASARR redone after the medication was started and they should have completed another PASARR.2. The record for Resident 38 was reviewed on 12/8/23 at 3:38 p.m. Diagnoses included, but were not limited to, chronic respiratory failure, hypertension, edema		cited have had new Level 1's completed 2 All Residents have the potential to be affected. Social Services and designees to be in-serviced on completing PASRR Level 1's upon change in diagnosis and/or medications being added. 3 Upon review in morning meeting of medication changes PASRR Level 1's will be initiated. This will be monitored by Executive Director or Designee daily in morning meeting. 4 Audits to ensure completion of PASRR Level 1's due to diagnosis/med changes will be completed five days per week by Executive Director or Designee and findings reported to QAPI Committee for review at monthly meeting. This will be on-going for six (6) months. If 100% compliance not achieved and action plan will be initiated. 5 Completed 1/5/24	

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	(swelling), psychotic disorder with delusions, and anxiety disorder. A PASARR level I, dated 1/12/23, indicated the resident was not on mental health medications. The mental health diagnoses were depression. A physician's order, dated 11/7/23, indicated buspirone (an antianxiety medication) 10 mg (milligrams) tablet give 1 tablet three times a day. A physician's order, dated 11/7/23, indicated haloperidol lactate concentrate 2mg/ml (an antipsychotic medication) 10 mg tablet give 1 tablet three times a day. During an interview, on 12/11/23 at 3:00 p.m., the DON indicated a new PASARR level I was not completed when the buspirone and haloperidol was ordered. During an interview, on 12/11/23 at 3:30 p.m., the SSD indicated a new PASARR Level I should have been completed when the resident started on buspirone (antianxiety) and haloperidol (antipsychotic). She should have completed a new PASARR level I when new medications or a diagnosis was added to the resident. A current policy, titled "PAS Paperwork," received by the Executive Director on 12/11/23 at 4:54 p.m., indicated "...Pre-Admission Screening (PAS) is a requirement for Nursing Facilities in the State of Indiana...The Pre-Admission Screening process determines the need for placement in a nursing facility and is two-fold. In Indiana, the State wants to be sure that placement is most appropriate for the individual person and to assure that any psychiatric and/or development needs are addressed in the facility...The Level I is			

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	to be completed with clinical information from the following: Social Services Director/Assistant: Will complete the sections of the Level I and Level of Care assessment that involve psychiatric/behavioral or discharge planning questions...." 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)			
F 0684 SS=E 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 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 weights and physician notification were completed as ordered for residents with congestive heart failure (CHF), to document accu checks (finger stick blood sugars) and insulin administration and failed to ensure a resident with routine orders for Ativan and morphine received the medication as ordered for 4 of 4 residents reviewed for quality of care. (Resident 8, 10, 75 and 81) Findings include: 1. The record for Resident 8 was reviewed on 12/07/23 at 9:39 a.m. Diagnoses included, but were not limited to, chronic (congestive) systolic heart failure and chronic kidney disease stage 3.	F 0684	1 It is the policy of the facility to follow physician orders, documenting weights and blood sugar checks and notifying physician when measurements are out of parameters dictated by Physician order. Each resident cited have had orders reviewed and being followed as physician ordered. Staff will be in-serviced on proper documentation and notification of physician as directed in physician orders. 2 All residents have the potential to be affected. All residents were reviewed to insure weight were obtained as ordered, accuchecks and insulin were	01/05/2024

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	A physician's order, dated to 10/19/23, indicated to obtain daily weights for congestive heart failure and to notify the physician for a weight gain of 3 pounds in a day or 5 pounds in a week. A Medication Administration Record (MAR), dated 10/1/23 to 10/31/23, indicated 4 missing weights for 10/14, 10/15, 10/16, and 10/19/2023. There was incomplete information on 10/3, 10/4, 10/5, and 10/6/23. A MAR, dated 11/1/23 to 11/30/23, indicated there was incomplete information for the daily weights on 11/1, 11/7, 11/9, 11/10, 11/13, 11/14, 11/15, 11/17, 11/19, 11/21, 11/22, and 11/26 through 11/30/23. The MAR indicated there was a weight of 102 pounds recorded on 11/6/23 and a weight of 105.5 pounds recorded on 11/7/23. A loss of 3.5 pounds was incorrectly documented for the weight gain of 3.5 pounds. There was no documentation the physician was notified of the weight gain. A weight of 96.6 pounds was documented on 11/12/23 and on 11/13/23 a weight of 100 was recorded. The gain of 3.4 pounds was not documented on the record. There was no documentation the physician was notified of the weight gain. A MAR, dated 12/1/23 to 12/31/23, indicated there was incomplete information for 12/1/23 and no weights recorded for 12/2 through 12/7/23. A physician's encounter summary-progress note, dated 12/5/23, indicated the resident's assessment and plan for congestive heart failure was to monitor for shortness of breath, increased edema, and continue to monitor weight. During an interview, on 12/7/23 at 2:00p.m., the Director of Nursing (DON) indicated the		documented for residents who receive Ativan and Morphine as ordered 3. The Dire ctor of Nursing or Designee will monitor ordered weights and Insulin checks and will be monitored 5 x a week for compliance. 4 The deficient practice will be monitored by te Director of Nursing and/or Designee 5 x a week for 4 weeks and then weekly for 6 months and if not 100 % compliance an action plan will be initiated and findings reported to QAPI Committee monthly. 5 Completed 1/5/24	

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	information should be complete and weights should be documented daily on the MAR. 2. The record for Resident 10 was reviewed on 12/8/23 at 10:27 a.m. Diagnoses included, but were not limited to, congestive heart failure, diabetes, hypertension, and atrial fibrillation. A care plan, dated as revised on 7/1/22, indicated the resident was at risk for fluid imbalance related to congestive heart failure. The interventions included, but were not limited to, weigh every Monday, Wednesday, and Friday. A physician's order, dated 12/2/22, indicated to weigh on Monday, Wednesday, and Friday and to notify the physician if there was a 5-pound increase in one week. The MAR, dated 8/8/23 through 12/7/23, indicated the resident missed weights on 8/9/23, 9/14/23, 11/1/23, 11/3/23, 11/7/23, and 12/4/23. During an interview, on 12/6/23 at 10:10 a.m., the Assistant Director of Nursing (ADON) indicated residents with congestive heart failure need to be weighed by 6:00 a.m. When a resident refused to be weighed, the staff should attempt multiple times and notify the physician if the resident continued to refuse. 3. The record for Resident 75 was reviewed on 12/07/23 at 9:47 a.m. Diagnoses included, but were not limited to, type II diabetes mellitus. A physician's order, dated 10/20/23, indicated Humalog Kwik pen insulin 100 units/ml, to administer 10 units 3 times daily. A physician's order, dated 10/16/23 to 11/21/23,			

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	indicated Humalog U-100 Insulin per sliding scale. A physician's order, dated 11/29/23, indicated Lantus Solostar U-100, to administer 10 units at bedtime. A physician's order, dated 11/30/23, indicated accu-checks before all meals and to call the MD if the blood sugar was less than 70 or greater than 400. A MAR, dated 10/1/23 to 10/31/23, indicated there was no documentation on 10/23/23 at 4:00 p.m., 10/24/23 at 7:00 a.m., and 10/30/23 at 4:00 p.m., for the Humalog 10 units. There was no documentation on 10/20/23 at 4:00 p.m., 10/23/23 at 4:00 p.m., 10/24/23 at 7:00 a.m., and 10/30/23 at 4:00 p.m., for the sliding scale insulin. A MAR, dated 11/1/23 to 11/30/23, indicated there was no documented administration of the Humalog 10 units at 7:00 a.m., on 11/6, 11/12, and 11/18/23. There was no documented administration of the Humalog 10 units at 11:00 a.m., on 11/5 and 11/12/23. There was no documented administration of the Humalog 10 units at 4:00 p.m., on 11/7, 11/9, 11/11, 11/12, 11/13, 11/16, 11/17, 11/20, 11/21, 11/23, and 11/25/23. A MAR, dated 12/1/23 to 12/31/23, indicated there were missing accu checks at 5:00 p.m., and 8:00 p.m., on 12/7/23. There was missing documentation of the Humalog 10 units at 7:00 a.m., on 12/2, and 12/6/23. There was missing documentation for the Humalog 10 units at 4:00 p.m., on 12/3 and 12/7/23. During an interview, on 12/11/23 at 3:00 p.m., the DON indicated the blood sugars and insulin administration should have been documented on			

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	the MAR.4. The record for Resident 81 was reviewed on 12/7/23 at 10:39 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, hearing loss, low back pain, acute kidney failure, dislocation of the right hip, and a cognitive communication deficit. A physician's order, dated 11/19/23, indicated to admit to hospice. A physician's order, dated 11/20/23, indicated to admit to hospice with a diagnosis of senile degeneration of the brain. A physician's order, dated 11/23/23, indicated to give lorazepam concentrate (an antianxiety) 0.25 milliliter (ml) every 4 hours routinely for anxiety and agitation. A physician's order, dated 11/23/23, indicated to give lorazepam concentrate 0.25 ml every 2 hours as needed for anxiety and agitation. A physician's order, dated 11/23/23, indicated to give morphine (a narcotic pain medication) 0.25 ml every 4 hours routinely for pain and shortness of breath. A physician's order, dated 11/23/23, indicated to give morphine 0.25 ml every 2 hours as needed for pain and shortness of breath. A hospice note, dated on 11/23/23 at 12:48 p.m., indicated the resident was not eating or drinking, and appeared to be transitioning. Comfort medications were ordered. The facility was encouraged to call hospice with any changes. The medication changes included morphine concentrate and to administer 0.25 ml.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A MAR, dated 11/01/23 through 11/24/23, indicated the resident received a dose of the routine morphine on 11/23/22 at 5:00 p.m., and it was administered late. The routine dose of the morphine scheduled for 11/23/23 at 9:00 p.m. was not given due to the medication was not available. The routine doses of the morphine scheduled for 11/24/23 at 1:00 a.m., 5:00 a.m., and 9:00 a.m., were not given due to the medication was not available. The MAR, dated 11/1/23 through 11/24/23, indicated the resident received one dose of the lorazepam on 11/23/23 at 5:00 p.m. and it was administered late. The routine dose of the lorazepam scheduled for 11/23/23 at 9:00 p.m. was not administered due to the medication was not available. The routine doses of the lorazepam scheduled for 11/24/23 at 1:00 a.m., 5:00 a.m., and 9:00 a.m., were not given due to the medication was not available. During an interview, on 12/8/23 at 11: 58 a.m., the Clinical Support Nurse indicated the routine lorazepam and morphine were not administered since the facility did not have the morphine or the lorazepam in the facility emergency drug kit. The lorazepam was on back order. The facility did not notify the hospice of the medications not being available. A current policy, titled "Hospice Policy," dated as revised on 8/19 and received from the Director of Nursing on 12/11/23 at 1:48 p.m., indicated "...It is the policy of this facility that when a resident elects the hospice benefit that the contracted hospice company and facility will coordinate to establish both a person centered plan of care reflecting the physical, spiritual, mental and psychosocial needs of the resident as well as a pattern of communication between the hospice			

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	company, healthcare professionals, facility staff and resident/representative...Facility staff will contact the hospice company with any significant change in the resident's condition...The Social Services Director or designee will act as the Hospice Coordinator which will be responsible for the following functions...Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family...." The facility did not have a weight policy for congestive heart failure. 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to ensure there was documentation in the Electronic Health Record to include if the resident went to the scheduled dialysis treatments for 1 of 2 residents reviewed for dialysis. Resident 39) Finding includes: The record for Resident 39 was reviewed on 12/7/23 at 10:38 a.m. Diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, congestive heart failure, generalized anxiety disorder, and chronic	F 0698	1 It is the policy of the facility to document when a resident does or does not go to dialysis. The resident #39 in question is no longer a resident at the facility. 2 All residents have the potential to be affected Staff to be in-serviced on necessary and appropriate documentation for residents receiving dialysis. All other Dialysis residents were reviewed for compliance.	01/05/2024

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	embolism and thrombosis of the right jugular vein. A physician's order, dated 6/20/23, indicated dialysis days on Monday, Wednesdays, and Fridays with a chair time of 9:15 a.m. The was no documentation in the Electronic Health Record (EHR) for 11/15/23, 11/22/23, 11/24/23 and 11/29/23 to indicate if the resident went to dialysis or did not go to dialysis. There were no progress notes, no dialysis events, and no dialysis communication form. There was no event for dialysis on 10/30/23, 11/6/23, 11/8/23, 11/10/23, 11/13/23, 11/27/23, 11/29/23 or 12/4/23 for the dialysis treatment. The facility provided a dialysis communication form, dated 11/29/23, with no resident name on the form. During an interview, on 12/11/23 at 11:57 a.m., the Clinical Support Nurse indicated the facility policy did indicate an event had to be completed when the resident went to dialysis. The dialysis facility was more concerned with the dialysis communication form which included the pre and post vital signs. During an interview, on 12/11/23 at 3:45 p.m., the Director of Nursing (DON) indicated the facility had no documentation on the dates in November listed above to show if the resident went to dialysis or not. The DON did not know if the resident went to dialysis or not on the dates in November. A current policy, titled "Dialysis Care," dated as revised on 11/2017 and received from the Clinical Support Nurse on 12/8/23 at 12:38 p.m., indicated		3 The Director of Nursing and/or Designee will monitor the days of treatment for all residents receiving dialysis to ensure proper documentation is in the chart. 4 Dialysis QAPI tool will be completed weekly x 4 weeks and monthly x 6 months If 100% not achieved an action plan will be developed. Findings from audit will be presented to the QAPI committee monthly for review. 5 Completed 1/5/24	

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	"...to ensure that residents requiring dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care, and the resident's goal and preferences. The facility will assure that each resident receives care and services for the provision of hemodialysis and/or peritoneal dialysis consistent with professional standards of practice including...Ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility...Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services...For those residents receiving dialysis at a certified dialysis facility...An assessment of the resident will be completed upon return from each dialysis visit to include vital signs and assessment of the site including bruit and thrill [if applicable], drainage and general condition...A dialysis event will be initiated in EMR [electronic medical record] to include time of transfer and completed on return to the unit...The facility will employ a method of communication between the facility and the dialysis center to relay changes in condition and response to treatment...." 3.1-37(a)			
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			

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	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 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, record review and interview, the facility failed to ensure the narcotic count sheets were signed by two nurses to verify the correct count of controlled substances between shifts for 2 of 3 medication carts reviewed. (the women's memory care medication cart and the Willow bend #2 medication cart) Findings include: 1. During an observation, on 12/7/23 beginning at 11:03 a.m., the following was observed on the "Shift Change Verification of Controlled Substances" form, dated December 2023, for the	F 0755	1 It is the Policy of the facility to sign off each shift the narcotics by counting and signing what is present by off going and on-coming nurses. 2 Nursing staff will be in-serviced on narcotic counts and required signatures between shifts. 3 Audits will be performed by Director of Nursing and/or Designee to ensure appropriate documentation is completed 4 QAPI tool will be completed	01/05/2024

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	women's memory care unit: a. The form was labeled the Cedar Bay unit for December 2023. a. The same nurse signed the on-coming nurse space and the off-going nurse space for the night shift on December 2. b. There were no nurse signatures on the day shift and evening shift for December 5. c. The same nurse signed as the on-coming and off-going nurse for the evening shift on December 6. d. There was only one nurse signature on the on-coming nurse space and no signature for the off-going nurse for the day shift on December 7. e. There was only one nurse signature on the off-going nurse space and no signature for the on-coming nurse on the evening shift for December 7. 2. During an observation, on 12/7/23 beginning at 12:11 p.m., the following was observed on the "Shift Change Verification of Controlled Substances" form for the Willow Bend #2 medication cart: a. The form did not include the month or the name of the unit. b. The same nurse signed as the on-coming and off-going nurse for the evening and night shift for the 6th. c. A different nurse signed as the on-coming and off-going nurse for the day shift on the 7th. During an interview, on 12/7/23 at 11:40 a.m., the Assistant Director of Nursing (ADON) indicated the facility had agency staff working on December 5, 2023, there were no nurse signatures on the count shift for December 5 and there should have been. The count should be verified between two different nurses.		weekly x 4 weeks and monthly x 6 months. If 100% compliance is not achieved an action plan will be submitted. Findings from audit will be presented to QAPI Committee for review. 5 Completed 1/5/24	

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	A current policy, titled "LTC [long term care] Facility's Pharmacy Services and Procedures Manual," dated as revised on 8/07/2023 and received from the Director of Nursing (DON) on 12/7/23 at 12:30 p.m., indicated "...Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security...." 3.1-25(e)(2) 3.1-25(e)(3)			
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure medications administered orally were separated from topical medications, to store cleaning supplies separately from medications, medication carts were clean and free of loose medications, medications were not relabeled for use for another resident, opened medications were dated, medications were stored in the refrigerator until opened, discontinued and expired medications were disposed of routinely and medication storage refrigerators were clean for 3 of 3 medication carts reviewed and 1 of 1 medication storage rooms reviewed. (The women's memory care medication cart, the men's memory care medication cart, the Willow Bend medication cart #2 and the women's memory care medication storage room). Findings include: 1. During a medication cart observation with the Assistant Director of Nursing (ADON), on 12/7/23 at 11:03 a.m., the women's memory care unit cart was observed to have the following: a. The top left drawer had bisacodyl (a stool softener) suppositories sitting next to one bottle of eye drops and sitting on top of mirtazapine (an antidepressant) oral tablets. There was a box of alcohol prep pads next to sertraline (an antidepressant) oral tablets. Liquid Refresh (an eye lubricant) eye drops were sitting next to oral mirtazapine tablets. b. The second left drawer had 7 loose pills and dirty debris and foil on the bottom. c. The third left drawer had Micro kill bleach wipes next to polyethylene glycol (a treatment for constipation) oral liquid. There was one box of lidocaine topical patches next to the oral medications.	F 0761	1 It is the policy of the facility to follow appropriate medication storage guidelines. Medications were separate, medications expired were destroyed medication storage was cleaned from oral and topical, cleaning supplies were removed from medication cart, medications not labeled were discarded, medication requiring refrigeration were destroyed 2 All residents have the potential to be affected. Med carts were immediately organized appropriately and medications properly stored in all medications cart. 3 The Director of Nursing and/or Designee will monitor for proper storage of medications 5 x a week to insure medications are separated appropriately, refrigerators are clean , outdated medications are destroyed. 4 QAPI tool will be completed weekly x 4 weeks and then monthly x 6months. If not 1005 an action plan will be initiated and findings presented QAPI Committee monthly and as needed for review. 5 Completed 1/5524.	01/05/2024

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	d. The second right drawer had lots of dirt, debris and one loose white pill on the bottom. There was one bottle of Humalog insulin for Resident 75 opened and not dated. One multidose vial of insulin lispro for Resident 134 with her name marked out and Resident 75's name handwritten on the label. One multidose vial of fluphenazine (an antipsychotic injection) opened and not dated. During an interview, on 12/7/23 at 11:28 a.m., the ADON indicated the insulin for Resident 134 should not have been relabeled with Resident 75's name. She was not aware the eye drops and topicals could not be stored with the oral medications. 2. During a medication cart observation with LPN 2, on 12/7/23 at 11:30 a.m., the following was observed: a. The top left drawer had one box of bisacodyl suppositories stored next to nitroglycerin sublingual (a medication for chest pain given under the tongue). There was two loose pills and debris on the bottom of the drawer. There was one bottle of calcitonin-salmon (nasal spray for pain relief) not opened for Resident 78 with a sticker to keep in the refrigerator until opened. b. The second left drawer had multiple loose white pills on the bottom of the drawer. c. The third left drawer had one bottle of a Ocusoft scrub (an eyelid cleanser) and nicotine topical patches next to the cards of oral medications. The bottom of the drawer had dirt and debris all over. d. The fourth left drawer had oral medications next to an enema kit and lidocaine topical patches. There was also a bottle of the Ocusoft scrub, fluticasone (allergy relief) nasal spray, and a bottle of oral liquid antacid all together.			

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	e. The top right drawer had a glucometer sitting directly on the bottom of the drawer and there were a pair of fingernail clippers right next to the glucometer. f. The second right locked controlled substance drawer had one card of lorazepam (an antianxiety medication) 0.5 milligram (mg) for Resident 50 with the foil removed and tape on the back of dose 4 and a pill under the tape. It also had one card of lorazepam 0.5 mg for Resident 8 with the foil removed and tape placed over the dose 17 and a pill under the tape. 3. During an observation, on 12/7/23 at 11:57 a.m., with the ADON, the medication room near the women's memory care unit was observed to have the following: a. A plastic bin approximately 18 inches tall with expired and discontinued medication cards and medication bottles which were overflowing and stacked to approximately 24 inches over the top of the bin. b. There was a cardboard box on the floor with two Binax (covid tests) kits in the box with an expiration date of 6/11/23. There was one package of cigarettes on top of the Binax kits. c. The medication refrigerator had at least 8 dead flies on the bottom drawer. During an interview, on 12/7/23 at 12: 09 p.m., the ADON indicated the pharmacy made daily deliveries and should pick up the expired and discontinued medications daily, but the nurses had to scan them first and were behind on getting the medications scanned. 4. During a medication storage observation, on 12/7/23 at 12:11 p.m., with the ADON, the following were observed for the Willow Bend cart #2:			

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	a. The bottom right drawer had 9 loose on the bottom. There was lots of dirt and debris on the bottom. b. The second right locked controlled medication drawer had one card of tramadol (narcotic pain reliever) 50 mg for Resident 23 with torn foil and tape on the back of doses 6 and 7 with a pill under the tape. c. The top drawer had yellow, red, and brown substances all over the sides and bottom of the drawer. There was one glucometer sitting directly on top of the sticky yellow, red, and brown substances. There was also one breo inhaler not packaged sitting on top of the yellow, red, and brown substances. A current policy, titled "LTC [long term care] Facility's Pharmacy Services and Procedures Manual," revised on 8/07/2023 and received from the Director of Nursing (DON) on 12/7/23 at 12:30 p.m., indicated "...sets forth the procedures relating to the storage and expiration dates of medications. biologicals, syringes and needles...Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts, refrigerators/freezers of sufficient size to prevent crowding...Facility should ensure that external use medications and biologicals are stored separately from internal use medications and biologicals...Topical [external] use medications or other medications should be stored separately from oral medications when infection control issues may be a consideration...Facility should ensure that test reagents, germicides, disinfectants, and other household substances are stored separately from medications...Facility staff should record the date opened on the primary medication container...when the medication has a shortened expiration date once opened...If a multi-dose vial			

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	of an injectable medication has been opened or accessed...the vial should be dated and discarded within 28 days unless the manufacturer specifies a different [shorter or longer] date for that opened vial...Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels or cautionary instructions...Facility should ensure that resident medication and biological storage areas are locked and do not contain non-medication/biological items...Facility should ensure that no transfers between containers are performed by non-Pharmacy personnel...Facility should ensure that medications and biologicals are stored at their appropriate temperatures...Facility should ensure that all controlled substances are stored in a manner that maintains their integrity and security...Facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider...Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other Applicable Law...Facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled basis...Facility should request that Pharmacy perform a routine nursing unit inspection for each nursing station in Facility to assist Facility in complying with its obligations pursuant to Applicable Law relating to the proper storage, labeling, security and accountability of medications and biologicals..." 3.1-25(j) 3.1-25(o) 3.1-25(p)			

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	3.1-25(r)			