STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE FORT HARRISON	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaints IN00364234 and IN00374615. Complaint IN00364234 - Substantiated. State Residential Findings are cited at R117. Complaint IN00374615 - Substantiated. State Residential Findings are cited at R117 and R240. Survey dates: April 7, and 8, 2022 Facility number: 014109 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 12, 2022	R 0000	04/23/2022 ISDH ATT: Brenda Buroker Director of Division Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 Re: Annual Survey Wickshire Fort Harrison 8025 Doubleday drive Indianapolis, IN 46216 Dear Ms. Buroker, On April 8, 2022, a State Residential Licensure with a Complaints (IN00364234, IN00374615) and Annual Survey was conducted at the above referenced facility by the Division of Long-Term Care. Please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency. Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance. We respectfully request a desk review that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of May 02,2022 Please feel free to call me with any further questions at 1 (317) -546-2846. Respectfully submitted,	

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 determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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			Romeo Behl (Executive Director) Wickshire Fort Harrison 8025 Doubleday drive	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	Based on observation, interview, and record review, the facility failed to implement the Controlled Substances Policy by not timely completing the community narcotics count form with the potential to affect 39 of 39 residents residing at the facility. Findings include: On 4/7/22 at 3:09 p.m., the facility medication cart was observed with QMA (Qualified Medication Aide) 2. The narcotic count binder contained a Controlled Substance Community Inventory Count Form, which instructed that the signatures of the oncoming and off going individuals would sign the form at each shift change. The form contained no signatures for the following days: 4/3/22 and 4/6/22. The form contained the signature of 1 QMA on 4/4/22 at 6:00 a.m., 4/52/22 at 6:00 a.m. and 6:00 p.m., and 4/7/22 at 6:00 a.m. and 6:00 p.m.	R 0091	**R0091 Administration and management** **The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1) **Immediate actions taken for those residents identified:** Count verified and narcotic sheets corrected by RDCO on 4/7/22.	05/02/2022

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	During an interview on 4/7/22 at 3:15 p.m., QMA 2 indicated that she had counted the narcotics in the medication cart with QMA 3 when she started her shift. She did not sign at that time because it was not 6:00 p.m. During an interview on 4/7/22 at 3:45 p.m., the RNC (Regional Nurse Consultant) indicated that the form should be completed and signed each time the medications were reconciled by both the outgoing and oncoming shifts. On 4/8/22 at 8:50 a.m., the RNC provided the Controlled Substances Policy, effective 11/01/2019, which read "...to ensure the special handling, storage, disposal, and record keeping of controlled substances according to applicable regulatory standard...5. Prior to the end of each shift the authorized associate that is reporting off duty will count the controlled substances with the authorized associate who is reporting on duty. 6. The counts will be recorded on the forms listed above a. Both associates will initial and sign the form verifying that the count is correct..."		New sheets printed so the category is legible and added to the narcotic binder on 4/7/22 by the RDCO. Education with QMAs completed by RDCO 4/7/22 and 4/8/22 then again by HWD on 4/28/22. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. Narcotic count audit to be completed by HWD/designee starting 4/20/22 and then weekly x4 weeks then monthly x 5 months. **3)Measures put into place/ System changes.**Narcotic count audit to be completed by HWD/designee starting 4/28/22 and then weekly x4 weeks then monthly x5 months.**4) How the corrective actions will be monitored:**The HWD/designee will be responsible for compliance. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	
R 0117	410 IAC 16.2-5-1.4(b) Personnel - Deficiency			

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Bldg. 00	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.			
	Based on interview and record review, the facility failed to ensure a Licensed Nurse or Qualified Medication Aide was available, at all times, to administer scheduled and as needed medications to residents at the facility for 4 of 6 residents reviewed for medication administration, and to ensure a staff person was working every shift that was certified in cardiopulmonary resuscitation (CPR) and first aid. This had a potential to effect 39 of 39 residents that reside in the facility. See R0240 for additional information regarding Resident F and Resident H. (Residents' C, D, F, H and	R 0117	**R 0117** Personnel - Deficiency **The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared**	05/02/2022

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	Certified Nursing Assistant (CNA) 3 and 4) Findings include: 1. The clinical record for Resident C was reviewed on 4/7/22 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, hypothyroidism and legal blindness. She was admitted to the facility on 11/25/2019. The physician's orders for March and April 2022 indicated she was to receive the following medications: - levothyroxine sodium (thyroid medication) 75 mcg (Micrograms) by mouth each morning at 6:00 a.m. -Janumet tablet (diabetic medication) 50-100 mg (Milligram) by mouth two times daily at 6:00 a.m. and 4:00 p.m. -Erythromycin ointment 5mg/gm (gram) 1 inch of ointment to left eye every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m., and -simvastatin (cholesterol medication) 20 mg by mouth daily at 8:00 p.m. The March and April 2022 MARs (Medication Administration Record) did not contain initials, indicating medication had been administered, as follows: - levothyroxine sodium 75 mcg- not signed off as administered on 3/2/22 through 3/11/22, 3/13/22 through 3/31/22 and 4/1/22 through 4/7/22, - Janumet tablet 50-100 mg- not signed off as administered at 6:00 a.m. on 3/2/22 through 3/11/22, 3/13/22 through 3/31/22 and 4/1/22 through 4/7/22, - Erythromycin ointment 5mg/gm- not signed off as administered at 12:00 a.m. and 6:00 a.m. on3/2/22 through 3/11/22, 3/13/22 through		**and/or executed solely because it is required by the provisions of federal and state law.** 1) **Immediate actions taken for those residents identified:** In servicing on medication administration was initiated on 4/8/22 by RDCO. HWD will complete 100% QMA education by 4/28/22. MD was notified for residents C, D, F, H missing signatures. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes.** ED to schedule CPR training for all leadership team, care partners, dietary and QMAs. Each shift will have minimum of 1 CPR certified associate on staff by 5/2/22. Any new nursing hire will complete CPR/First aide training by end of orientation. **HWD will review 6 residents MARS weekly x 4 weeks ,4 residents MARS weekly x 4 weeks and then 2 residents MARS weekly x 4 months.** **4) How the corrective actions will be monitored:** The BOM/HWD/designee will be responsible for compliance. BOM will audit employee files weekly x4 weeks then monthly x5 months to ensure compliance.	

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	3/31/22, and 4/1/22 through 4/7/22, 3/3/22, 3/21/22, 3/28/22, and 4/1/22 at 6:00 p.m., and 3/5/22 and 4/4/22 at 12:00 p.m., and - Simvastatin 20mg- not signed off as administered at 8:00 p.m. on 3/3/22, 3/25/22, 3/28/22, 4/1/22 and 4/4/22. 2. The clinical record for Resident D was reviewed on 4/7/22 at 2:50 p.m. The resident's diagnosis included, but were not limited to, diabetes and hypertension. He was admitted to the facility on 12/23/2017. The physician's orders for March and April 2022 indicated he was to receive the following medications: -glimepiride (diabetic medication) 1 mg daily by mouth before breakfast at 6:00 a.m., - carvedilol (heart medication) 3.125 mg two times daily at 9:00 a.m. and 9:00 p.m., and -simvastatin 40 mg by mouth daily at 7:00 p.m. The March and April 2022 MARs did not contain initials, indicating medication had been administered, as follows: - glimepiride 1mg- not signed off as administered on 3/2/22 through 3/11/22, 3/13/22 through 3/31/22, and 4/1/22 through 4/7/22, -carvedilol 3/125 mg- not signed off as administered at 9:00 p.m. on 3/3/22, 3/25/22, 3/28/22, 4/1/22 and 4/4/22, -simvastatin 40 mg- not signed off as administered on 3/3/22, 3/25/22, 3/27/22, 4/1/22 and 4/4/22. 3. The clinical record for Resident F was reviewed on 4/7/22 at 1:45 p.m. The diagnoses included, but were not limited to, depression, neuropathy, hyperlipidemia, and anxiety.		**HWD will review 6 residents MARS weekly x 4 weeks ,4 residents MARS weekly x 4 weeks and then 2 residents MARS weekly x 4 months.** Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	

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	The physician's orders indicated to administer one 60 mg capsule of duloxetine once daily, effective 4/1/20; one 400 mg capsule of Gabapentin after meals, effective 4/18/20; two 400 mg capsules of Gabapentin at bedtime, effective 4/18/20; one 20 mg tablet of Lipitor once daily, effective 4/1/20; one 20 mg tablet of Xarelto once daily, effective 4/1/20; and one 5 mg tablet of Zyprexa at bedtime, effective 4/1/20. The February, March, and April 2022 MARs (medication administration records) indicated she did not receive the Duloxetine on the following days: 2/11/22, 2/24/22, 3/4/22, 3/5/22, 3/25/22, 3/31/22, 4/2/22, 4/4/22, and 4/5/22. She did not receive the Gabapentin after meals on the following dates and times: 2/6/22 after dinner, 2/11/22 after lunch, 2/24/22 after lunch, 2/26/22 after dinner, 2/28/22 after dinner, 3/4/22 after lunch, 3/5/22 after lunch, 3/21/22 after dinner, 3/25/22 after lunch, 3/28/22 after dinner, 4/1/22 after dinner, 4/2/22 after lunch, 4/4/22 after breakfast and lunch, and 4/5/22 after lunch. She did not receive the Gabapentin at bedtime on the following dates: 2/15/22, 2/16/22, 2/22/22, 2/23/22, 2/25/22, 2/26/22, 2/27/22, 2/28/22, 3/1/22, 3/2/22, 3/6/22, 3/12/22, 3/13/22, 3/14/22, 3/20/22, 3/23/22, 3/25/22, 3/28/22, 4/1/22, and 4/4/22. She did not receive the Lipitor on the following dates: 2/15/22, 2/16/22, 2/22/22, 2/23/22, 2/25/22, 2/2622, 2/27/22, 2/28/22, 3/1/22, 3/2/22, 3/6/22, 3/12/22, 3/13/22, 3/14/22, 3/20/22, 3/23/22, 3/25/22, 3/28/22, 4/1/22, and 4/4/22. She did not receive the Xarelto on 2/6/22 and 3/21/22. She did not receive the Zyprexa on the following dates: 2/25/22, 2/26/22, 2/28/22, 4/1/22, and 4/4/22.			

An interview was conducted with Resident Ton 4/7/22 at 2:30 p.m. She indicated staff administered her medications. Sometimes she received them, and sometimes she did not, as staff did not always administer them. She definitely missed some Gabapentin administrations.

4. The clinical record for Resident H was reviewed on 4/7/22 at 2:30 p.m. Resident H's diagnosis included, but was not limited to, hypertension. Resident H was admitted to the facility on 7/6/21.

A physician order dated 10/11/21 indicated the resident was to receive 100 milligrams of docusate at bedtime.

A physician order dated 2/3/22 indicated the staff was to administer 50 milligrams of metoprolol at bedtime.

A physician order dated 10/11/21 indicated the resident was to receive 15 milligrams of mirtazapine at bedtime.

The February 2022 MAR indicated the following medications and dates Resident H did not receive her medications:
metoprolol 50 milligrams - 2/22/22, 2/25/22, 2/26/22,
mirtazapine 15 milligrams - 2/22/22, 2/25/22, 2/26/22, and
docusate 100 milligrams - 2/22/22, 2/25/22, 2/26/22

The March 2022 MAR indicated the following medications and dates Resident H did not receive her medications:

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docusate 100 milligrams - 3/6/22, 3/13/22, 3/25/22. 3/26/22,
metoprolol 50 milligrams - 3/13/22, 3/25/22, 3/28/22, and
mirtazapine 15 milligrams - 3/13/22, 3/25/22, 2328/22

An interview was conducted with Resident H on 4/7/22 at 2:39 p.m. She indicated she has missed evening medications, because there were no nursing staff available to give them.

An interview was conducted with the RNC (Regional Nurse Consultant) on 4/7/22 at 2:55 p.m. She indicated she was unaware there was a problem with residents not getting their medications.

On 4/8/22 at 3:16 p.m., the Executive Director provided the Daily Schedule, as worked, for March 27,2022 through April 2, 2022, which indicated that there was not a QMA (Qualified Medication Aide) or a Licensed Nurse scheduled for the night shift on the following days: 3/27/22, 3/28/22 from 3:00 a.m. till 6:00 a.m., 3/29/22, 3/30/22, 3/31/22, 4/1/22 from 12:00 a.m. till 6:00 a.m., and 4/2/22.

During an interview on 4/8/22 at 3:30 p.m., the Executive Director indicated that there was not always a QMA on the night shift and, at times, they left at around 9 p.m., The facility had been without a permanent DON (Director of Nursing) since the middle of February 2022, so there was not a on call nurse who could have come in and administered needed medications during the night shift. She had been told there were not medication that needed passed between 9:00 p.m. and 5:00 a.m. There had not been a staff member available for as needed medications to have been

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given if any of the residents had requested them.

A Pharmaceutical Services policy was provided by the Regional Nurse Consultant on 4/8/22 at 8:50 p.m. It indicated " ...3. If the community controls, handles, and administers medications for a resident, the community will do the following for that resident: a. Make arrangements to ensure, that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana ..."
5. The staff worked scheduled dated 3/27/22 - 4/2/22, and the staff that were CPR and first aid certified was provided by the Executive Director (ED) on 4/8/22 at 3:16 p.m. It indicated CNA 3 was CPR certified but did not include first aid. CNA 4 was certified in CPR and first aide. The following dates, shifts, there were no staff working in the building CPR and/or first aide certified:

Sunday, 3/27/22 - day, evening and night shift, - no staff CPR/first aid certified,
Monday, 3/28/22 - day shift - no first aide, evening, and night shift - no staff CPR/first aid certified,
Tuesday, 3/29/22 - day shift - no first aide, night shift - no staff CPR/first aid certified,
Wednesday, 3/30/22 - day shift - no first aide, night shift - no staff CPR/first aid certified,
Thursday, 3/31/22 - day shift - no first aide, night shift - no staff CPR/first aid certified,
Friday, 4/1/22 - day shift - no first aide, evening and night shift - no staff CPR/first aid certified,
Saturday, 4/2/22 - day and night shift - no staff CPR/first aid certified

An interview was conducted with the ED 4/8/22 at 3:30 p.m. She indicated she was only able to

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	provide CNA 4 and CNA 3 certification in CPR and/or first aid certification. CNA 3's CPR card only indicated she had completed CPR not first aid. This Residential tag relates to Complaints IN00374615 and IN00364234.			
R 0121 Bldg. 00	410 IAC 16.2-5-1.4(f)(1-4) Personnel - Noncompliance (f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete			

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	a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out.			
	Based on interview and record review, the facility failed to ensure Mantoux tuberculin skin test and/or risk assessments were conducted annually and/or new hire staff for 3 of 5 staff personal files reviewed. (Certified Nursing Assistant (CNA) 5 and 6 and Dietary Manager (DM) 7) Findings include: The personnel files were provided by the Executive Director (ED) on 4/8/22 at 3:16 p.m. It indicated CNA 5 and CNA 6 were full time employees. The personnel file for CNA 6 was reviewed. It indicated CNA 6 had a start date of 9/26/17. The last screening for tuberculosis was dated on 1/30/19. There were no additional screenings in her file. The personnel file for DM was reviewed. It indicated DM had a start date of 5/16/19. It did not include 1st; 2nd step tuberculin skin test or an annual risk assessment. The personnel file for CNA 5 was reviewed. It indicated CNA 5 had a start date 12/27/21. It did not include 1st; 2nd step of tuberculin skin test or a risk assessment completed for CNA 5.	R 0121	**R0121** Personnel - noncompliance **The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1) **Immediate actions taken for those residents identified:**Audit all associates for missing job items. Send all associates missing their complete 2 step TB screening to Concentra. All TB's to be completed by 5/2/22.**2) How the facility identified other residents:** Any resident residing in the facility had the potential to be	05/02/2022

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	An interview was conducted with the ED on 4/8/22 at 3:30 p.m. She indicated she was unable to provide tuberculin skin tests that were conducted, or annual risk assessments completed for CNA 6, DM, and CNA 5.		affected. **3)Measures put into place/ System changes.**Send all associates missing their complete 2 step TB screening to Concentra. All new hires TB screening will be completed and reviewed by BOM before start date. **4) How the corrective actions will be monitored:** The BOM/designee will be responsible for compliance. BOM will audit employee files weekly x 4 weeks then monthly x5 months to ensure compliance. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	
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 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.			

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	(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 interview and record review, the facility failed to ensure a self-medication assessment was conducted quarterly for 1 of 6 residents reviewed, and to ensure a Resident Needs Assessment was conducted quarterly, per policy, and included quarterly or upon an acute change the elopement, mobility, and mini mental assessments for 1 of 6 residents reviewed. (Resident 6 and 27) Findings: 1. The clinical record for Resident 27 was reviewed on 4/7/22 at 11:30 a.m. Resident 27's diagnosis included, but was not limited to, chronic kidney disease. Resident 27 was admitted to the facility on 9/4/21. A self-medication assessment dated 9/2/21, indicated Resident 27 was able to self-medicate. The instructions on the assessment indicated, " ...The resident who desires to self-administer medication(s) with or without staff supervision, will have a physician's order to do so in his/her Resident Record. Place a checkmark in the appropriate box below for each of the items listed. The resident must be able to demonstrate basic competency ("able with assist" or fully capable") in each applicable step prior to receiving initial or continuing approval for self-administration of any medication. The Nurse will be responsible for approving self-administration of medications, or staff	R 0216	R0216 EVALUATION The facility requests paper compliance for this citation. This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1) **Immediate actions taken for those residents identified:** QMAs were educated and trained by clinical specialist on screenings (self-med if they give their own meds, skin (monthly), mini mental, elopement, fall risk, mobility on 3/23/22. Schedule created and assigned by RDCO on 3/31/22. Updated on 4/12/22 QMAs In-service and training scheduled on screenings, schedule, and expectations by HWD by 4/28/22 2) How the facility identified other residents:	05/02/2022

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	supervised self-administration of medications, using this review as a guide. An evaluation should be completed initially, quarterly or per state regulations, and with a change of condition ..." The clinical record for Resident 27 did not include quarterly self-medication assessments completed for the resident. An interview was conducted with the Regional Nurse Consultant 4/8/22 on 2:16 p.m. She indicated the residents that self-medicate should be evaluated quarterly. She was unable to locate a quarterly self-medication assessment conducted for Resident 27. A "Self-Administration of Medication" policy was provided by the Executive Director on 4/8/22 at 1:16 p.m. It indicated " ...Policy" ...3. Review of the resident's ability to self-administer medications will take place at a minimum semi-annually ..." A "Resident Needs Assessment" policy was provided by the RNC on 4/8/22 at 8:45 a.m. It indicated "...8...The Self administration of medications form will only be required to be completed quarterly or upon an acute change in condition for those residents that self-administer their medications..." 2. The clinical record for Resident 6 was reviewed on 4/7/22 at 12:06 p.m. Resident 6's diagnoses included, but not limited to, hypertension, osteoporosis (weak bones), essential tremor, and anxiety. Resident 6's last quarterly Mini Mental State Examination was conducted on 7/20/21 and indicated, Resident 6 had a moderate cognitive impairment. The facility did not conduct Mini		Any resident residing in the facility had the potential to be affected. 3)Measures put into place/ System changes. Screening audit to be completed by HWD/designee on all residents by 4/26/22, and then 7 residents weekly x 4 months then 7 residents every other month x 5 months **4) How the corrective actions will be** monitored: The HWD/designee will be responsible for compliance. HWD will audit 7 residents weekly x 4 months then 7 residents every other month x 5 months to ensure compliance**.** Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction. 5) Date of compliance: 05/02/2022	

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Mental State Exams quarterly.

A Behavior note dated 10/13/2021 at 12:15 a.m. indicated, Resident 6 was found outside the facility by herself without an escort. She had also been found in the hallway without any clothes on. The non-pharmacological intervention was to remind "her she fell the other day an [sic, and] if she we[sic, were] outside alone we might not find her for a while however she forgets".

Resident 6's last quarterly Elopement Risk assessment was completed on 7/20/21. The facility did not conduct an Elopement Risk assessment quarterly, nor after the 10/13/21 incident.

Resident 6's last quarterly Fall Risk assessment was completed on 7/20/21. It indicated; Resident 6 was a high fall risk. The facility did not conduct quarterly Mobility/Fall Risk assessments.

According to Resident 6's progress notes, she had falls on the following dates: 8/22/21, 10/3/21, 12/17/21, and 2/11/22.

An interview with RNC (Regional Nurse Consultant) was conducted on 4/8/22 at 10:20 a.m. RNC indicated, the Resident Needs Assessment was recently changed from bi-annually to quarterly which resulted in the facility's triggering mechanism for the needed assessment to "fall off". She indicated; she had just realized that 3 weeks ago.

A Resident needs Assessment policy was received from RNC on 4/8/22 at 8:45 a.m. The policy indicated, a completed Resident Needs

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	Assessment should be done at the time of admission then quarterly or when resident's condition of level of care changes. The ancillary forms for elopement, mobility and mini mental status were to be completed quarterly and/or with an acute change in condition.			
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on interview and record review, the	R 0217	R0217 EVALUATION	05/02/2022

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	facility failed to ensure service plans were signed by the resident and/or resident's representative for 4 of 6 residents reviewed. (Residents' 27, C, D, and 6) Findings include: 1. The clinical record for Resident 27 was reviewed on 4/7/22 at 11:30 a.m. Resident 27's diagnosis included, but was not limited to, chronic kidney disease. Resident 27 was admitted to the facility on 9/4/21. A resident evaluation/service plan for Resident 27 was completed on, 9/3/22. There was no resident signature or resident representative signature on the service plan. 2. The clinical record for Resident C was reviewed on 4/7/22 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, hypothyroidism and legal blindness. She was admitted to the facility on 11/25/2019. The clinical record did not contain a service plan that had been signed by her or her representative. 3. The clinical record for Resident D was reviewed on 4/7/22 at 2:50 p.m. The resident's diagnosis included, but were not limited to, diabetes and hypertension. He was admitted to the facility on 12/23/2017. The clinical record did not contain a service plan signed by him or his representative. 4. The clinical record for Resident 6 was reviewed on 4/7/22 at 12:06 p.m. Resident 6's diagnoses included, but not limited to, hypertension, osteoporosis (weak bones), essential tremor, and anxiety.		**The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1) **Immediate actions taken for those residents identified:**Concierge will schedule all residents for a care conference starting the week of 4/25/22. All residents will have a current care conference scheduled by 5/2/22. ED/HWD or designee will hold care conference and ensure Service plan is signed by resident, POA, or 2 associates present during the care conference.**2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes.**Care Conference audit will be completed by ED/designee each month for 7 months.	

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	Resident 6's last quarterly Mini Mental State Examination was conducted on 7/20/21 and indicated, Resident 6 had a moderate cognitive impairment. Resident 6's clinical record indicated, the last Service Plan/Level of Care was completed on 3/30/22 and was not signed by the resident's POA (Power of Attorney) nor Resident 6. During an interview on 4/8/22 at 8:50 a.m., the RNC (Regional Nurse Consultant) indicated that she could not find signed service plans in the clinical records for Resident C, Resident D Resident 27 or Resident 6. A "Resident Needs Assessment" policy was provided by the RNC on 4/8/22 at 8:45 a.m. It indicated "...11. The Residents Individualized Service/Support plan is then generated and signed by all appropriate individuals. 12. The signed Resident Individualized Service/Support plan is then uploaded into the resident chart..."		**4) How the corrective actions will be monitored:** The ED/designee will be responsible for compliance. Audit will be completed by ED/designee each month for 7 months. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 7 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on interview and record review, the facility failed to administer a resident's medication, as ordered, for 4 of 6 residents' medications reviewed and 2 of 5 residents randomly observed for medication administration, and to implement the elopement/missing resident policy by not conducting quarterly elopement risk assessments nor after two elopement attempts and not	R 0240	R 0240 Health Services – Deficiency **The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or**	05/02/2022

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	notifying the resident representative of elopement behaviors timely; not implementing the Fall and Mobility Management policy by not conducting fall risk assessment after every fall episode and/or every six months and not placing additional fall interventions in the Service/support plan for 1 of 5 residents whose clinical records were reviewed. (Residents' C, D, F, H, L, M and 6) Findings include: 1.The clinical record for Resident F was reviewed on 4/7/22 at 1:45 p.m. The diagnoses included, but were not limited to: depression, neuropathy, hyperlipidemia, and anxiety. An interview was conducted with Resident T on 4/7/22 at 2:30 p.m. She indicated staff administered her medications. Sometimes she received them, and sometimes she did not, as staff did not always administer them. She missed some Gabapentin administrations. The physician's orders indicated to administer one 60 mg capsule of duloxetine once daily, effective 4/1/20; one 400 mg capsule of Gabapentin after meals, effective 4/18/20; two 400 mg capsules of Gabapentin at bedtime, effective 4/18/20; one 20 mg tablet of Lipitor once daily, effective 4/1/20; one 20 mg tablet of Xarelto once daily, effective 4/1/20; and one 5 mg tablet of Zyprexa at bedtime, effective 4/1/20. The February, March, and April 2022 MARs (medication administration records) indicated she did not receive the Duloxetine on the following days: 2/11/22, 2/24/22, 3/4/22, 3/5/22, 3/25/22, 3/31/22, 4/2/22, 4/4/22, and		**agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1) **Immediate actions taken for those residents identified:** Education completed by Clinical specialist with QMAs on 3/23/22 and Re-education will be completed by HWD on 4/28/22.**2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes.**Incident Report audit to be completed by HWD/designee on 4/28/22, and then weekly x 4 weeks then monthly x 5 months for accuracy. **4) How the corrective actions will be monitored:** The HWD/designee will be responsible for compliance. Audit will be completed by HWD/designee weekly x 4 weeks then monthly x5 months to ensure compliance. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if	

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	4/5/22. She did not receive the Gabapentin after meals on the following dates and times: 2/6/22 after dinner, 2/11/22 after lunch, 2/24/22 after lunch, 2/26/22 after dinner, 2/28/22 after dinner, 3/4/22 after lunch, 3/5/22 after lunch, 3/21/22 after dinner, 3/25/22 after lunch, 3/28/22 after dinner, 4/1/22 after dinner, 4/2/22 after lunch, 4/4/22 after breakfast and lunch, and 4/5/22 after lunch. She did not receive the Gabapentin at bedtime on the following dates: 2/15/22, 2/16/22, 2/22/22, 2/23/22, 2/25/22, 2/26/22, 2/27/22, 2/28/22, 3/1/22, 3/2/22, 3/6/22, 3/12/22, 3/13/22, 3/14/22, 3/20/22, 3/23/22, 3/25/22, 3/28/22, 4/1/22, and 4/4/22. She did not receive the Lipitor on the following dates: 2/15/22, 2/16/22, 2/22/22, 2/23/22, 2/25/22, 2/2622, 2/27/22, 2/28/22, 3/1/22, 3/2/22, 3/6/22, 3/12/22, 3/13/22, 3/14/22, 3/20/22, 3/23/22, 3/25/22, 3/28/22, 4/1/22, and 4/4/22. She did not receive the Xarelto on 2/6/22 and 3/21/22. She did not receive the Zyprexa on the following dates: 2/25/22, 2/26/22, 2/28/22, 4/1/22, and 4/4/22. An interview was conducted with the RNC (Regional Nurse Consultant) on 4/7/22 at 2:55 p.m. She indicated she was unaware there was a problem with residents not getting their medications. 2. The clinical record for Resident H was reviewed on 4/7/22 at 2:30 p.m. Resident H's diagnosis included, but was not limited to, hypertension. Resident H was admitted to the facility on 7/6/21. A physician order dated 10/11/21 indicated the resident was to receive 100 milligrams of docusate at bedtime. A physician order dated 2/3/22 indicated the		changes need made to the plan of correction. **5) Date of compliance: 05/02/2022**	

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	staff was to administer 50 milligrams of metoprolol at bedtime. A physician order dated 10/11/21 indicated the resident was to receive 15 milligrams of mirtazapine at bedtime. The January 2022 Medication Administration Record (MAR) indicated the following medications and dates Resident H did not receive her medications: docusate 100 milligrams - 1/8/22, 1/16/22, 1/18/22, 1/20/22, and mirtazapine 15 milligrams - 1/8/22, 1/16/22, 1/18/22, 1/20/22, A nursing progress note dated, 1/12/22 indicated "Evening medications missed ..." The February 2022 MAR indicated the following medications and dates Resident H did not receive her medications: metoprolol 50 milligrams - 2/22/22, 2/25/22, 2/26/22, mirtazapine 15 milligrams - 2/22/22, 2/25/22, 2/26/22, and docusate 100 milligrams - 2/22/22, 2/25/22, 2/26/22 The March 2022 MAR indicated the following medications and dates Resident H did not receive her medications: docusate 100 milligrams - 2/6/22, 2/13/22, 2/25/22. 2/26/22, metoprolol 50 milligrams - 2/13/22, 2/25/22, 2/28/22, and mirtazapine 15 milligrams - 2/13/22, 2/25/22, 2/28/22 An interview was conducted with Resident H on			

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4/7/22 at 2:39 p.m. She indicated she has missed evening medications because there were no nursing staff available to give them.

3. The clinical record for Resident C was reviewed on 4/7/22 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, hypothyroidism and legal blindness. She was admitted to the facility on 11/25/2019.

The physician's orders for March and April 2022 indicated she was to receive the following medications:
- levothyroxine sodium (thyroid medication) 75 mcg (Micrograms) by mouth each morning at 6:00 a.m.
-Janumet tablet (diabetic medication) 50-100 mg (Milligram) by mouth two times daily at 6:00 a.m. and 4:00 p.m.
-Erythromycin ointment 5mg/gm (gram) 1 inch of ointment to left eye every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m., and
-simvastatin (cholesterol medication) 20 mg by mouth daily at 8:00 p.m.

The March and April 2022 MARs (Medication Administration Record) did not contain initials, indicating medication had been administered, as follows:
- levothyroxine sodium 75 mcg- not signed off as administered on 3/2/22 through 3/11/22, 3/13/22 through 3/31/22 and 4/1/22 through 4/7/22,
- Janumet tablet 50-100 mg- not signed off as administered at 6:00 a.m. on 3/2/22 through 3/11/22, 3/13/22 through 3/31/22 and 4/1/22 through 4/7/22,
- Erythromycin ointment 5mg/gm- not signed off as administered at 12:00 a.m. and 6:00 a.m. on3/2/22 through 3/11/22, 3/13/22 through 3/31/22, and 4/1/22 through 4/7/22, 3/3/22,

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		A. BUILDING 00 B. WING	04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE FORT HARRISON	8025 DOUBLEDAY DRIVE INDIANAPOLIS, IN 46216

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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

3/21/22, 3/28/22, and 4/1/22 at 6:00 p.m., and 3/5/22 and 4/4/22 at 12:00 p.m., and
- Simvastatin 20mg- not signed off as administered at 8:00 p.m. on 3/3/22, 3/25/22, 3/28/22, 4/1/22 and 4/4/22.

4. The clinical record for Resident D was reviewed on 4/7/22 at 2:50 p.m. The resident's diagnosis included, but were not limited to, diabetes and hypertension. He was admitted to the facility on 12/23/2017.

The physician's orders for March and April 2022 indicated he was to receive the following medications:
-glimepiride (diabetic medication) 1 mg daily by mouth before breakfast at 6:00 a.m.,
- carvedilol (heart medication) 3.125 mg two times daily at 9:00 a.m. and 9:00 p.m., and
-simvastatin 40 mg by mouth daily at 7:00 p.m.

The March and April 2022 MARs did not contain initials, indicating medication had been administered, as follows:
- glimepiride 1mg- not signed off as administered on 3/2/22 through 3/11/22, 3/13/22 through 3/31/22, and 4/1/22 through 4/7/22,
-carvedilol 3/125 mg- not signed off as administered at 9:00 p.m. on 3/3/22, 3/25/22, 3/28/22, 4/1/22 and 4/4/22,
-simvastatin 40 mg- not signed off as administered on 3/3/22, 3/25/22, 3/27/22, 4/1/22 and 4/4/22.

5. The clinical record for Resident M was reviewed on 4/8/22 at 10:35 a.m. The Resident's diagnosis included, but were not limited to, hypertension and heart failure.

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	A physician's order, dated 5/5/2021, indicated she was to receive amlodipine besylate (blood pressure medication) 5 mg daily for her hypertension. It was to be held if her B/P (blood pressure) was less than 150/90. On 4/8/22 at 9:20 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications to Resident M. She removed the medications, including the amlodipine besylate, from the medication cart and placed them into a plastic medication cup. She entered the room and obtained her blood pressure reading as 94/68. She then administered the medications to her. She left the room and wrote the blood pressure reading on a piece of paper and signed off the medications as given on the MAR. 6. The clinical record for Resident L was reviewed on 4/8/22 at 10:45 a.m. The Resident's diagnosis included, but were not limited to, hypertension and edema (swelling). A physician's order, dated 10/28/2021, indicated she was to receive Lasix (water pill) 20 mg daily for edema. On 4/8/22 at 9:45 a.m., QMA 3 was observed administering medications to Resident L. She removed the pre-packaged medications from the medication cart and compared the medications listed on the packaging to the MAR. She indicated that the packaged medications did not include Lasix 20 mg. She then looked to see if there was a container of Lasix 20 mg available for her to use. She indicated that there was not a container of Lasix 20 mg for her and that sometimes medications get left out of the pre-packaged doses. She would call the pharmacy later to address it. She placed the			

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	pre-packaged medications into a plastic medication cup and administered them to her. She did not administer the Lasix 20 mg. During an interview on 4/8/22 at 12:30 p.m., the RNC (Regional Nurse Consultant) indicated that Resident M's amlodipine besylate should have not been administered due her blood pressure being lower that 150/90 and that Resident L should have received her Lasix as ordered by the physician. During an interview on 4/8/22 at 3:30 p.m., the RNC indicated that Resident C and D should have received their medications as ordered. A Pharmaceutical Services policy was provided by the Regional Nurse Consultant on 4/8/22 at 8:50 p.m. It indicated " ...3. If the community controls, handles, and administers medications for a resident, the community will do the following for that resident: a. Make arrangements to ensure, that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana ..." 7. The clinical record for Resident 6 was reviewed on 4/7/22 at 12:06 p.m. Resident 6's diagnoses included, but not limited to, hypertension, osteoporosis (weak bones), essential tremor, and anxiety. Resident 6's last quarterly Mini Mental State Examination was conducted on 7/20/21 and indicated, Resident 6 had a moderate cognitive impairment. Resident 6's latest Resident Evaluation/Service Plan dated 3/30/22 indicated, in the behavior and safety section, the following was noted: "Went			

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	through the front door once in past 3 months but was easily redirected back in." A Behavior note dated 10/13/2021 at 12:15 a.m. indicated, Resident 6 was found outside the facility by herself without an escort. She had also been found in the hallway without any clothes on. The non-pharmacological intervention was to remind "her she fell the other day an [sic, and] if she we[sic, were] outside alone [sic] we might not find her for awhile however[sic] she forgets". An interview with RNC (Regional Nurse Consultant) was conducted on 4/8/22 at 10:20 a.m. RNC indicated, the incident mentioned in the 3/30/22 evaluation/Service plan occurred just a few months ago and is not the same incident from 10/13/22. Resident 6's last quarterly Elopement Risk assessment was completed on 7/20/21. The facility did not conduct an Elopement Risk assessment quarterly, nor after the 10/13/21 incident. An interview with Resident 6's representative was conducted on 4/7/22 at 3:27 p.m. She indicated; she had not been informed of her mother being found outside the facility on 10/13/21. A Resident needs Assessment policy was received from RNC on 4/8/22 at 8:45 a.m. The policy indicated, a completed Resident Needs Assessment should be done at the time of admission then quarterly or when resident's condition of level of care changes. The ancillary forms for elopement, mobility and mini mental status were to be completed quarterly and/or with an acute change in condition.			

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An Elopement/Missing Resident policy was received on 4/8/22 at 8:45 a.m. from RNC. The policy indicated, residents should have been assessed for elopement risks upon a significant change in condition and at regular intervals to identify risk factors that could have led to elopement. Once identified as an elopement risk, interventions should have been put in place to minimize the risk for elopement. When the missing resident was located, all parties will be informed, and a physical assessment should have been completed. The Executive Director and Health and Wellness Director were to document all notifications, communications, and outcomes on an Elopement/Missing Resident form.

Resident 6's last quarterly Fall Risk assessment was completed on 7/20/21. It indicated; Resident 6 was a high fall risk. The facility did not conduct quarterly Mobility/Fall Risk assessments.

According to Resident 6's progress notes, she had fallen on the following dates: 8/22/21, 10/3/21, 12/17/21, and 2/11/22. The clinical record for Resident 6 did not contain completed fall risk assessments for the dates previously mentioned.

A Falls and Mobility Management policy was received 4/8/22 at 8:45 a.m. from RNC. The policy indicated, a fall risk assessment should have been done at least every six months and after every fall episode. If the resident had a fall, the community should have had documentation of the analysis of circumstances of the fall and interventions that were initiated to prevent or reduce the risk of further falls. The service/support plan should have had specific

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	interventions to decrease falls. An interview with RNC was conducted on 4/8/22 at 10:20 a.m. RNC indicated, the fall intervention that had been put in place after the 12/17/21 fall was to monitor Resident 6's pain medication however, Resident 6 did not receive any pain medications which could have contributed to her fall. No additional fall interventions were added to Resident 6's service plan after the fall on 2/11/22. This Residential tag relates to Complaint IN00374615.			
R 0299 Bldg. 00	410 IAC 16.2-5-6(c)(3) Pharmaceutical Services - Noncompliance (3) The medication review, recommendations, and notification of the physician, if necessary, shall be documented in accordance with the facility ' s policy. Based on interview and record review, the facility failed to timely complete pharmacy recommendations for 3 of 5 residents reviewed for pharmacy recommendations (Resident C, D and F). Findings include: 1. The clinical record for Resident C was reviewed on 4/7/22 at 2:10 p.m. The Resident's diagnosis included, but were not limited to, hypothyroidism and legal blindness. She was admitted to the facility on 11/25/2019. On 4/8/22 at 9:30 a.m., the RNC (Regional Nurse Consultant) provided the Note to Attending Physician/ Prescriber forms, printed 2/18/22, for Resident C. The forms had not been	R 0299	R0299 Pharmaceutical Services **The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1) **Immediate actions taken**	05/02/2022

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	signed by a physician. 2. The clinical record for Resident D was reviewed on 4/7/22 at 2:50 p.m. The resident's diagnosis included, but were not limited to, diabetes and hypertension. He was admitted to the facility on 12/23/2017. On 4/8/22 at 9:30 a.m., the RNC (Regional Nurse Consultant) provided the Note to Attending Physician/ Prescriber forms, printed 2/18/22, for Resident D. The forms had not been signed by a physician. 3. The clinical record for Resident F was reviewed on 4/7/22 at 1:45 p.m. The diagnoses included but were not limited to: depression and neuropathy. The current physician's orders indicated to administer one 60 mg capsule of duloxetine once daily, effective 4/1/20; one 400 mg capsule of Gabapentin after meals, effective 4/18/20; and two 400 mg capsules of Gabapentin at bedtime, effective 4/18/20. The 2/18/22 Note to Attending Physician/Prescriber read, "Please evaluate signs and symptoms of depression to determine if a dose reduction is appropriate at this time. If not appropriate, please document rationale. Duloxetine 60 mg once daily - Recommend decreasing to: duloxetine 30 mg once daily." The Physician/Prescriber Response section of the note was blank. The 2/18/22 Note to Attending Physician/Prescriber read, "This resident has an order for Gabapentin 400 mg with meals + 800 mg at bedtime. This resident has a most recent		**for those residents identified:**Guardian Pharmacy and My Mobile notified by ED about concerns and My mobile or PCP to address last 3 months of pharmacy recommendation by 4/22/22. HWD will ensure orders are enter in EHR and resident/POA notified of changes. **2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes.**Pharmacy audit to be completed no later than 5/2/22 by HWD/designee and then monthly x 5 months. **4) How the corrective actions will be monitored:** The HWD/designee will be responsible for compliance. Audit will be completed by HWD/designee no later 5/2/22 and then monthly x 5 months. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	

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	GFR (Glomerular filtration rate-test used to check how well the kidneys are working) of 47 mL/min [minute.] Gabapentin is renally excreted and recommended to be dosed based on renal function. Please evaluate this order to determine if a dose adjustment is appropriate at this time. Gabapentin Renal Dosing - CrCl 30-59 mL/min - - 400 - 1400 mg/day in two divided doses." The Physician/Prescriber Response section of the note was blank. There was no information in the clinical record to indicate the two 2/18/22 pharmacy recommendations were reviewed by the physician/prescriber. An interview was conducted with the RNC (Regional Nurse Consultant) on 4/8/22 at 8:50 a.m. She indicated the February 2022 pharmacy recommendations had not been addressed by the physician. On 4/8/22 at 8:50 a.m., the RNC provided the Pharmaceutical Services Policy, effective 11/1/2019, which read "...b. A consultant pharmacist will be employed, or under contract, and will...review the drug regimen of each resident receiving these services at least once every sixty [60] days. c. The medication review recommendations and notifications of the physician, if necessary, will be documented in accordance with the community's policy..."			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date.			

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	(D) Name of drug. (E) Strength. Based on observation, interview and record review, the facility failed to adequately label over the counter medications for 3 of 39 residents. (Resident 15, 35, and F) Findings include: On 4/7/22 at 3:10 p.m., the facility medication cart was observed with QMA (Qualified Medication Aide) 2. It contained the following: a bottle of Tylenol 500 mg (milligrams) with Resident 15's room number written on the top of the lid. A bottle of preservision (vitamin) and a bottle of ibuprofen 200 mg with Resident 35's room number written on the top of the lid, and a bottle of multivitamins labeled with Resident F's room number. The bottles were not labeled with the name of the resident or the physician's name. During an interview on 4/8/22 at 9:00 a.m., the RNC (Regional Nurse Consultant) indicated that over the counter medications should be labeled with the resident's name and prescribing physician, along with the room number. On 4/8/22 at 8:50 a.m., the RNC provided the Pharmaceutical Services Policy, effective 11/1/2019, which read "...6. Over- the- counter medications must be identified with the following: a. Resident name. b. Physician name. c. Expiration date. d. Name of the drug. e. Strength..."	R 0302	R0302 OTC **The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1)**Immediate actions taken for those residents identified:** New labels ordered by 4/15/22. Education with all QMAs will be completed by HWD by 4/28/22. All OTCs labeled with Physician name, resident name, and medication name. Label will not cover original label showing medication name and strength or expiration date.**2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes.**OTC audit to be completed by HWD/designee on all carts and every OTC bottle to	05/02/2022

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			ensure compliance and then weekly x 4 weeks then monthly x 5 months. **4) How the corrective actions will be monitored:** The HWD/designee will be responsible for compliance. Audit will be completed by HWD/designee weekly x 4 weeks and then monthly x5 months. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care;			

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	(C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on interview and record review, the facility failed to ensure a transfer form was provided to the receiving facility that included name of transferring institution, the resident's functional abilities and physical limitations, nursing care needed, the resident's condition at transfer, date of chest x-ray and skin test for 1 of 2 residents closed charts reviewed. (Resident 63) Findings include: The clinical record for Resident 63 was reviewed on 4/7/22 at 2:30 p.m. Resident H's diagnosis included, but was not limited to, hypertension. Resident 63 was admitted to the facility on 7/27/15. A nursing progress note dated 2/25/22 indicated, "Resident [J] discharged to another assisted living facility ...All medications provided along with discharge instructions and paperwork." The transfer form for Resident 63 was provided by the Regional Nurse Consultant on 4/8/22 at 1:00 p.m. The following information was not included on the transfer form: Transferring institution, functional abilities and physical limitations, nursing care needed, primary physician information, the resident's condition at transfer, date of chest x-ray and skin test.	R 0354	R0354 Transfer forms **The facility requests paper compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1) **Immediate actions taken for those residents identified:** Transfer sheets will have Identification data, name of transferring institution, name of receiving institution and date of transfer, personal property, medications, diet orders, diagnosis, and functional ability printed at front desk by 5/2/22. Education with care partners, leadership, and QMAs on where to grab the transfer sheet and what section to complete at time of transfer held by HWD by 04/28/2022**2) How the facility**	05/02/2022

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	An interview was conducted with the Regional Nurse Consultant on 4/8/22 at 2:45 p.m. She indicated she was unaware the information required on the transfer form.		**identified other residents:** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes.**Transfer forms audit will be completed by HWD/designee on all current residents weekly x 4 weeks then monthly x5 months to ensure compliance. **4) How the corrective actions will be monitored:** The HWD/designee will be responsible for compliance. Audit will be completed by HWD/designee weekly x 4 weeks and then monthly x 5 months. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	
R 0414 Bldg. 00	410 IAC 16.2-5-12(k) Infection Control - Deficiency (k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Based on observation, interview, and record	R 0414	R0441- Infection Control **The facility requests paper**	05/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/08/2022

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	review, the facility failed to assure hand hygiene was performed prior to administering medications for 3 of 5 residents randomly observed for medication administration (Resident M, 16, and L). Findings include: On 4/8/22 at 9:20 a.m., QMA (Qualified Medication Aide) 3 was observed administering medications to Resident M. She removed the medications from the medication cart and placed them into a plastic medication cup. She did not perform hand hygiene prior to placing the medications into the medication cup, she entered the room and obtained her blood pressure reading as 94/68. She then handed her the medication cup, and she took her medications. She then moved her walker closer to her bed and picked up some items off the floor. She left the room and wrote the blood pressure reading on a piece of paper and signed off the medications as given on the MAR. She did not perform hand hygiene after leaving the room. She then began preparing Resident 16's medications. She removed them from the cart and opened them, placing them in a plastic medication cup without performing hand hygiene first. She then entered her apartment and handed the medication to her. She touched her shoulder after administering the medications and then left the apartment. She did not perform hand hygiene after leaving the apartment. She signed off the medications in the MAR. She then began preparing Resident L's medications. She did not perform hand hygiene prior to removing the pre-packaged medications from the medication cart and compared the medications listed on the packaging to the MAR. She placed the pre-packaged medications into a plastic medication cup. She then entered the		**compliance for this citation.This Plan of Correction is the center's credible allegation of compliance.** **Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.** 1)**Immediate actions taken for those residents identified:Initiated handwashing and infection control in servicing on 4/8/22. 2) How the facility identified other residents:** Any resident residing in the facility had the potential to be affected. **3)Measures put into place/ System changes.**100% of associates educated on handwashing and infection control by 4/28/22. HWD/designee will audit 4 associates weekly on random shifts for 4 weeks, then 3 associates a week x 3 months, and then 2 associates weekly x2 months. **4) How the corrective actions will be monitored:** The HWD/designee will be responsible for compliance. Audit	

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	apartment and administered them to her. She left the apartment and performed hand hygiene. During an interview on 4/8/22 at 10:05 a.m., QMA 3 indicated she should have performed hand hygiene after leaving each apartment and before beginning to prepare medications for administration. On 4/8/22 at 12:30 p.m., the Executive Director provided the Handwashing Policy, effective 11/1/2019, which read "...1. Handwashing should be completed before coming on duty, before and after direct or indirect resident contact, before and after performing any bodily functions, before preparing or serving food, before preparing or administering medications..."		will be completed by HWD/designee for 4 associates weekly on random shifts for 4 weeks, then 3 associates a week x 3 months, and then 2 associates weekly x2 months. Any issues identified will be immediately addressed. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 90% compliance is achieved x3 consecutive months. QA Committee will determine if changes need made to the plan of correction.**5) Date of compliance: 05/02/2022**	