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	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SANDERS GLEN	334 S CHERRY ST WESTFIELD, IN 46074

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R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00440968 and IN00435958. Complaint IN00440968 - State deficiencies related to the allegations are cited at R0064 and R0304. Complaint IN00435958 - No deficiencies related to the allegation were cited. Survey dates: August 26 and 27, 2024. Facility number: 005657 Residential Census: 102 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review was completed on September 3, 2024.	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance Based on interview and record review, the facility failed to protect a resident's medication from loss or theft when the resident's narcotic medication went missing from the narcotic box and the narcotic count sheet was also missing for 1 of 3 residents reviewed for misappropriation of property. (Resident B) Finding includes: An incident report filed to the Indiana State Department of Health, on 8/9/24, indicated a resident had Norco (a narcotic medication) 7.5/325	R 0064	*Corrective action for affected identified resident* Facility made notification to the Indiana Department of Health and the Westfield Police Department regarding the missing medication. Affected resident's medication was refillable if needed. Affected resident, discontinued using the identified medication. Facility will assume the cost of replacement medication as appropriate. *Identification and corrective action*	09/13/2024

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

Sue Hamaker | Administrator | 09/13/2024

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	milligram (mg) missing along with the narcotic count sheet. The clinical record for Resident B was reviewed on 8/26/24 at 12:43 p.m. The diagnoses included, but were not limited to, asthma, fibromyalgia (a condition which causes widespread pain and tenderness) and low back pain. A physician's order, initiated on 7/16/24, indicated to give one hydrocodone (Norco) 7.5 milligrams/325 milligrams (mg) every four hours as needed for pain. A physician's order, initiated on 7/16/24, indicated to give one hydrocodone-acetaminophen 7.5 mg/325 mg every six hours as needed for pain. A typed statement from the facility, dated 8/11/24, indicated QMA 1 did not count the narcotics with the on-duty nurse when she came to work. The statement included a typed name belonging to QMA 1. A written statement, dated 8/9/24 at 7:30 a.m., indicated LPN 3 did not find a narcotic count sheet or the narcotic card for the hydrocodone-acetaminophen 7.5/325 mg pills. The items were present on her 8/8/24 shift. She checked the resident's chart for an order to discontinue the medications and did not find one. The Medication Administration Record (MAR) indicated it was an active order. The incident was reported to LPN 4 who reported it to the Director of Nursing. During an interview, on 8/26/24 at 12:57 p.m., Resident B was alert and oriented. Resident B indicated she was unable to recall the day, but one morning she started to experience pain and		*for other residents with the potential to be affected:* All residents have the potential to be affected. Director of Nursing and Asst. Director of Nursing conducted a comprehensive review of all resident medication. No additional medication was determined to be absent. *Measures to prevent recurrence:* All nursing staff licensed to administer medication were educated regarding the safeguarding of resident medication and the facility policy regarding medication count, specific to controlled medication. Nursing staff educated to ensure the accuracy of narcotics maintained in the respective medication carts. Per facility policy, narcotics are maintained under double locks. Narcotic counts will be conducted upon every shift change and/or with every transfer of medication cart responsibility. Narcotic counts will be conducted in pairs. Specific educational material, policies and procedures will be maintained in narcotic book for immediate access and reference as appropriate. *How will the facility monitor and who is responsible:* Charge Nurse, Unit Manager and/or Designee will monitor narcotic logs daily to ensure compliance with accuracy of counts during shift change and/or	

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	asked for a pain pill. She asked QMA 5 for the pain medication. When QMA 5 returned to the resident's room, she informed Resident B she had already received a pain pill earlier. Resident B indicated she told the QMA she had not had the medication. Resident B was informed she was out of the medication and a police report needed to be filed to refill the narcotics. During a phone interview, on 8/26/24 at 4:19 p.m., QMA 1 indicated the evening nurse (LPN 2) was still in the building doing paperwork, when she arrived for her shift. She did not count the narcotics with the nurse at the beginning of her shift. She accessed the medication cart, set up the medications for the morning medication pass and left the keys to the medication cart in the narcotic book. She then left and went to another side of the building. The keys to the medication cart were left unattended and unsecured in the narcotic book. She indicated per the facility policy she was to count/account for all the narcotics at the change of shift. During a telephone interview, on 8/27/24 at 9:54 a.m., LPN 3 indicated she came into work around 6:30 a.m., and counted the medications. She indicated Resident B had not taken the medication oxycodone and acetaminophen 7.5/325 mg, for a couple of weeks. The narcotic log for the medication was the first one in the book. She had offered the pain medication the day before and the resident declined. LPN 3 remembered the count on the sheet was 26, as it was the last entry on the sheet. When she counted the narcotics that morning, the sheet was not in the book and the narcotics were not in the cart. She then checked the medical record to see if the narcotic had been discontinued and found it had not been discontinued. She then asked another staff		transfer of responsibility. Any discrepancies will be reported immediately to Director of Nursing and/or Administrator. Review of logs will be maintained in the Narcotic Count Book and provide a compliance acknowledgement signed by the Charge Nurse/Director of Nursing or Administrator, after reviewing the previous 24 hours for compliance for a period of 90 Days. Monthly monitoring will be included in the facility Quality Assurance program for review and/or corrective action.	

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	member, LPN 4, to recheck. LPN 4 did not find the narcotic sheet or narcotics. LPN 4 then contacted the Director of Nursing and alerted her to the situation. LPN 3 indicated she did not get the keys to the medication cart from anyone, they were left in the narcotic book, she took the keys and counted, alone. She indicated it was a "habit" to leave the medication cart keys in the narcotic book. The keys were not to be left unsecured and unattended. During an interview, on 8/27/24 at 10:43 a.m., the Director of Nursing indicated at the beginning of the shift the off-going nursing staff was to read from the narcotic book and the on-coming nursing staff was to review the medications in the narcotic box. The staff were to ensure the information in the narcotic logbook and the medications in the cart and, if applicable, the medication refrigerator, matched. Once the count was completed, both the on-coming and off-going staff were to sign the narcotic logbook. The keys to the medication storage carts/refrigerators were to be kept with the nurse in charge of the cart and medications were not to be set up for a future medication pass. During a telephone interview, on 8/27/24 at 11:01 a.m., LPN 2 indicated she was the off-going nurse from the evening shift. When QMA 1 came to work, she was still doing paperwork. She counted the narcotics by herself, this was her "habit", then she would count the narcotics with the on-coming nursing staff. She went to find QMA 1, but she did not find her. She did not see QMA 1 at all that night. She put the keys to both medication carts in the narcotic books. LPN 2 indicated she knew it was a bad habit. She had worked in the facility for 12 years and had built trust with other staff. She indicated the staff were not to leave the keys unsecured and were supposed to count the			

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	narcotics with the on-coming/off-going nurse/QMA and sign the book. A facility policy, titled "RESIDENTIAL CARE POLICIES AND PROCEDURES," dated as issued 3/4/19 and received from the Executive Director on 8/27/24 at 8:45 a.m., indicated "...SUBJECT: RESIDENT BILL OF RIGHTS and FREE FROM ABUSE...The facility shall exercise reasonable care for the protection of residents; property from loss and theft...." A facility policy, titled "RESIDENTIAL CARE POLICIES AND PROCEDURES," dated as issued 5/1/15 and received from the Executive Director on 8/27/24 at 8:45 a.m., indicated "...Subject: CONTROLLED SUBSTANCES...In addition to the Medication Sheet and the Schedule II Narcotic sheet, the number of controlled substances on hand must be counted and verified at the end of each shift. The Narcotic Sign In Sheet must be completed at the end of each shift every day. The outgoing Nurse or her designee will count all controlled substances being stored at the community while the oncoming Nurse or his or her designee watches. Both staff members sign that the count and verification have been completed...." This citation relates to Complaint IN00440968.			
R 0304 Bldg. 00	410 IAC 16.2-5-6(e) Pharmaceutical Services - Deficiency Based on interview and record review, the facility failed to ensure medication carts were appropriately locked and facility staff did not leave the keys to the medication carts in the narcotic books for 1 of 1 medication cart reviewed for misappropriation of property.	R 0304	*Corrective action for affected identified resident* Affected resident's medication will be safeguarded in the same manner as all resident medication with the same corrective actions.	09/13/2024

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	Finding includes: During a phone interview, on 8/26/24 at 4:19 p.m., QMA 1 indicated the evening nurse (LPN 2) was still in the building doing paperwork, when she arrived for her shift. She did not count the narcotics with the nurse at the beginning of her shift. She accessed the medication cart, set up the medications for the morning medication pass and left the keys to the medication cart in the narcotic book. She then left and went to another side of the building. The keys to the medication cart were left unattended and unsecured in the narcotic book. She indicated per the facility policy she was to count/account for all the narcotics at the change of shift. During a telephone interview, on 8/27/24 at 9:54 a.m., LPN 3 indicated she came into work around 6:30 a.m., and counted the medications. She indicated Resident B had not taken the medication oxycodone and acetaminophen 7.5/325 mg, for a couple of weeks. The narcotic log for the medication was the first one in the book. She had offered the pain medication the day before and the resident declined. LPN 3 remembered the count on the sheet was 26, as it was the last entry on the sheet. When she counted the narcotics that morning, the sheet was not in the book and the narcotics were not in the cart. She then checked the medical record to see if the narcotic had been discontinued and found it had not been discontinued. She then asked another staff member, LPN 4, to recheck. LPN 4 did not find the narcotic sheet or narcotics. LPN 4 then contacted the Director of Nursing and alerted her to the situation. LPN 3 indicated she did not get the keys to the medication cart from anyone, they were left in the narcotic book, she took the keys and		*Identification and corrective action for other residents with the potential to be affected:* All residents have the potential to be affected. Education was given to all nursing staff who administer medication to residents. Nursing staff were educated to the safeguarding of facility medication carts, specific to the transfer of keys and company property during shift change. Nursing staff educated to report to Director of Nursing, Unit Nurse and/or Administrator in the event replacement staff is not present at shift change. Director of Nursing, Unit Manager and/or Administrator will facilitate the transfer of keys and company property to oncoming staff as necessary. *Measures to prevent recurrence:* Nursing staff educated to keep medication cart keys on their person at all times. Nursing staff who administer medication to residents have been educated to ensure the keys are handed directly to another appropriately licensed member of the nursing staff. Key and property transfer protocol will be permanently maintained in each cart's medication record log. *How will the facility monitor and who is responsible:* Administrator, Director of Nursing and/or Designee will monitor compliance with medication cart key safeguarding by overseeing	

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	counted, alone. She indicated it was a "habit" to leave the medication cart keys in the narcotic book. The keys were not to be left unsecured and unattended. During an interview, on 8/27/24 at 10:43 a.m., the Director of Nursing indicated at the beginning of the shift the off-going nursing staff was to read from the narcotic book and the on-coming nursing staff was to review the medications in the narcotic box. The staff were to ensure the information in the narcotic logbook and the medications in the cart and, if applicable, the medication refrigerator, matched. Once the count was completed, both the on-coming and off-going staff were to sign the narcotic logbook. The keys to the medication storage carts/refrigerators were to be kept with the nurse in charge of the cart. During a telephone interview, on 8/27/24 at 11:01 a.m., LPN 2 indicated she was the off-going nurse from the evening shift. When QMA 1 came to work, she was still doing paperwork. She counted the narcotics by herself, this was her "habit", then she would count the narcotics with the on-coming nursing staff. She went to find QMA 1, but she did not find her. She did not see QMA 1 at all that night. She put the keys to both medication carts in the narcotic books. LPN 2 indicated she knew it was a bad habit. She had worked in the facility for 12 years and had built trust with other staff. She indicated the staff were not to leave the keys unsecured and were supposed to count the narcotics with the on-coming/off-going nurse/QMA and sign the book. During an interview, on 8/27/24 at 11:18 a.m., the Executive Director indicated the staff (in charge of the medications) were to keep the keys to the medication carts with them. The facility followed		shift change process and unscheduled compliance inspections multiple times each week, for a period of 90 days. Non-compliance with safeguarding cart keys may be subject to discipline and will be included in the facility's monthly Quality Assurance program.	

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	the state regulations. A facility policy, titled "RESIDENTIAL CARE POLICIES AND PROCEDURES," dated as issued 5/1/15 and received from the Executive Director on 8/27/24 at 8:45 a.m., indicated "...Subject: CONTROLLED SUBSTANCES..." did not address securing the keys to the medication storage carts and rooms. The facility was not able to provide a policy related to securing keys by the exit conference on 8/27/24. This citation relates to Complaint IN00440968.			