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	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SUGAR GROVE SENIOR LIVING COMMUNITY	5865 SUGAR LN PLAINFIELD, IN 46168

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R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to Investigation of Complaint IN00375925 completed on April 1, 2022. Complaint IN00375925 - Not Corrected Unrelated deficiencies are cited at R0216, R0217, R0246, and R0295. Survey dates: June 10, 2022. Facility number: 012394 Residential Census: 134 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 21, 2022.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. This statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of any revisit.	
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment. Based on record review and interview, the facility failed to follow their plan of correction (POC) to ensure staff notified the physician and/or resident's family of a significant change or a	R 0036	It is the intent of this facility to ensure that upon change of any medical condition, physician notification is completed.	07/08/2022

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

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	change in treatments. This deficient practice had the potential to effect 134 of 134 residents who resided in the facility. Findings include: On 6/10/22 at 10:04 a.m., the Administrator (ADM) provided the plan of correction (POC) binder. Upon review the binder did not contain any education, in-service documentation for staff members regarding notification of physician or resident's family The facility's POC indicated upon hire, orientation with new staff would include education for notification of the physician and all licensed staff in the community would receive education. On 6/10/22 at 10:30 a.m., during an interview the ADM indicated she was hired in April and the education took place before she had arrived at the facility. The Director of Nursing (DON) would have had the education documentation in her office. On 6/10/22 at 11:10 a.m., during an interview, the DON indicated she had been employed by the facility since April. She came to the facility right after the ADM. She did not locate the education documentation. She had done one in-service education, since she had been at the facility, on insulin pen use. She provided a copy of the printed instructions for Levemir (a type of insulin) and Humalog (a type of insulin) from the manufacturer. She did not provide any documentation showing date, time of the education, presenter or a list of attendees. The education should have been done, as indicated in the POC, but she was not able to locate the education documents or sign off sheets.		Corrective Action: Residents and families are being notified of medical condition change along with medical condition change specifically related to blood glucose levels. Licensed staff in-service will be completed by 7/5/2022 for Physician\Family notification on condition changes. Identification of other Residents: All residents have the potential to be affected by the deficient practice. An audit of the last 30 days of 100% of residents will be conducted to determine if there have been recent condition changes and if notification was made to MD and family. Notifications as appropriate will be made in accordance with the audit findings. Measures: Upon orientation with new staff, training will be provided regarding MD\family notification of condition change. All licensed nurses in the community will educated on the state regulation and Community Policy entitled “Significant Condition Change and Notification.” All community licensed Nursing Staff was educated on 6/28/22. An audit tool will be completed to monitor blood glucose levels and to ensure that MD\family notification is completed per “Significant Condition Change and Notification”	

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	This deficiency was cited on 4/1/22. The facility failed to implement a systemic plan of correction to prevent recurrence.		Policy. DON \ Designee will monitor audit tool 5 days a week for 1 month, 3 days a week for 1 month, then weekly for 1 month. Monitored: Executive Director \ Designee, in collaboration with Director of Nursing\Designee will review audits with QA Committee monthly x 3 months and will continue to review audit results monthly for duration of extended timeframe as applicable. Completion Date: 7/8/2022	
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. (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 observations, interviews, and record reviews, the facility failed to residents' with medications in their room had self-administration assessments to include the residents' ability to self-administer medications for 4 of 10 residents randomly observed for medications (Residents H, K, J, and L).	R 0216	It is the intent of this facility to ensure that residents' with medications in their room have had self-administration assessments which include the residents' ability to self -administer medications.	07/08/2022

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	Findings include: 1. On 6/10/22 at 9:30 a.m., Resident H was observed in her room. There were two bottles of medication on top of her microwave in the kitchenette. She indicated she only took two medications daily, so it was pretty easy. She did not recall the names of the medications but knew they were for blood pressure. She had not been told where or how her medication should be stored, they were just always on top of her microwave to make it easier to remember. Resident H indicated she usually pulled her door closed when she left the room but did not always lock the door. On 6/10/22 at 1:15 p.m., Resident H's medical record was reviewed. She had current active diagnoses which included, but were not limited to, Hypertension (HTN, high blood pressure). Her current physician orders for Amlodipine and Atenolol (both medications treat high blood pressure). She had 4 additional prescriptions for, Caltrate (a calcium supplement), Aspirin 81, Alendronate (a medication used to help treat osteoarthritis) and docusate (a stool softener). A handwritten note on her physician order set indicated, "Self-Administer." The most recent Self-Administration and Service Plan Assessment was dated 9/28/2020. The record lacked documentation that regular assessments had been completed every 6 months as required and did not provide a more up to date assessment of the resident' ability to self-administer her medication 2. On 6/10/22 at 9:38 a.m., Resident K's door was		Corrective Action: Director of Nursing and Assistant Director of Nursing was in-serviced on 6/27/2022 on Self-Administration of Medication Assessment including Semi-Annual Evaluations & Service Plans. Identification of Other Residents: All residents have the potential to be affected by the deficient practice. An Audit of residents was completed over the past 30 days to ensure that all residents that self medicate have up to date self medication administration assessments and medications are stored appropriately. This audit will be completed by 7/8/2022. Measures: An audit tool will be completed to ensure that all residents who self medicate will have appropriate self administration assessment completed as well as semi-annual assessments and service plans per protocol. DON \ Designee will monitor audit tool 5 days a week for 1 month, 3 days a week for 1 month, then weekly for 1 month. All Community licensed nursing staff was educated on 6/28/2022 and agency Monitored: Executive Director \ Designee, in collaboration with Director of Nursing\Designee will review audits with QA Committee monthly x 3 months and will continue to review audit results monthly for duration of extended	

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	observed opened. She was asleep in her bed but woke easily to a knock. Upon entrance into her a room, a prescription bottle was noted to be left on a table beside her recliner chair. Inside the bottle, there was a glass vile of Cyanocobalamin (an injectable B-12 supplement). Resident K indicated the nurse must have forgotten it. On 6/10/22 at 1:20 p.m., Resident K's medical record was reviewed. She had current active diagnoses which included, but were not limited to, edema, asthma, incomplete paraplegia at the 1st/4th/5th cervical vertebra, and diabetes mellitus. Her current physician order list, dated 6/30/22, indicated in hand-written script, "Self-Administers." The record lacked documentation of a current service plan. The record lacked documentation of a current medication self-administration assessment of the resident's ability to self-administer her medications. 3. On 6/10/22 at 9:56 a.m., Resident J was observed in his room. His room was cluttered with personal items which included but were not limited to various prescription and over the counter medications/vitamins. On 6/10/22 at 1:30 p.m., Resident J's medical record was reviewed. He had current diagnoses which included but were not limited to, depression, COPD (chronic obstructive pulmonary disease) and chronic back pain. His current physician order list, dated 6/30/22, did		timeframe as applicable. Completion Date: 7/8/2022	

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	not indicate his ability to self-administer his medications. The record lacked documentation of a current service plan. The record lacked documentation of a current medication self-administration assessment of the president's ability to self-administer her medications. 4. On 6/10/22 at 10:35 a.m., Resident L's apartment door was open, and she was not there. A moment later she was observed as she returned from the laundry room with a basket of clothes on her walker. Resident L indicated she always left her door open because there was nothing to steal. A bottle of Tums (an OTC anti-acid) was observed on an end-table beside her couch. She indicated she took those whenever she needed to for heart burn. On 6/10/22 at 1:25 p.m., Resident L's medical record was reviewed. She had active diagnoses which included, but were not limited to dementia, diabetes mellitus and HTN. Her current physician order set did not include an order for Tums. The record lacked documentation of current service plan. The record lacked documentation of a current medication self-administration assessment of the president's ability to self-administer her medications. During an interview on 6/10/22 at 1:38 p.m., the Director of Nursing (DON) indicated, she had			

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	completed new admission assessments since her new hire date in April of 2022, however, she had not had the time to audit other resident charts to ensure assessments were being completed on a regular basis and as needed, at least on a semiannual basis. On 6/10/22 at 2:38 p.m., the Administrator (ADM) indicated there was no facility policy on assessments and/or regularly scheduled evaluations, but it was her expectation that the facility followed the state regulations to complete evaluations at least on a semi-annual basis, which should include the resident's ability self-administer medications or not. On 6/10/22 at 2:00 p.m., the Administrator (ADM) provided a copy of current facility policy titled, "Self Administration of Medications," revised 5/20/20. The policy indicated, "... each resident is offered the opportunity to self-administer his or her medication during the routine assessments of the facilities interdisciplinary team ... if the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the residents cognitive, physical, and visual ability to carry out this responsibility, during the care planning process ... if the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medications storage is conducted...."			
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			

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	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 interviews and record reviews, the facility failed to ensure regular assessments and evaluations of the resident's needs and services were completed at a minimum on a semiannual basis for 6 of 10 residents randomly reviewed for medications (Residents B, C, D, E, F, and G). Findings include: On 6/10/22 at 1:30 p.m., the Administrator (ADM) provided requested most current service plan documentation for Residents B, C, D, E, F, and G (who were observed during a random medication administration observation).	R 0217	It is the intent of this facility to ensure that regular assessments and evaluations of the resident's needs and services be completed at a minimum on a semiannual basis. Corrective Action: Director of Nursing and Assistant Director of Nursing was in-serviced on 6/27/2022 on Self-Administration of Medication Assessment including Semi-Annual Evaluations & Service Plans. Identification of Other Residents:	07/08/2022

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	a. Resident B, admission date 1/5/21, had no service plan provided. b. Resident C, admission date 3/31/20, the most current service plan, 6 month (180 day) was dated 6/15/20. c. Resident D, admitted 9/25/18, the most current service plan, 6 month (180 day), was dated 9/28/20. d. Resident E, admitted 12/5/14, the most current service plan, 6 month (180 day), was dated 3/5/20. e. Resident F, admitted on 8/6/21, had 25 care plans initiated 3/30/22 and 4/11/22, signed off by the facility's former Assistant Director of Nursing. There was no service plan provided. f. Resident G, admitted on 11/1/16, the most current service plan, 6 month (180 day), was dated as 6/16/20. On 6/10/22 at 2:38 p.m., during an interview, the Administrator indicated, she did not know why the former ADON had created care plans for resident F instead of a service plan. She was no longer employed at the facility. There was no policy on semi-annual assessments, they were working on them (to make current).		All residents have the potential to be affected by the deficient practice. An Audit of residents was completed over the past 30 days to ensure that all residents assessments (including semi-annual evaluations and service plans). This audit will be completed and all residents will have current assessment by 7/8/2022. Measures: An audit tool will be completed to ensure that all residents will have assessments completed and timely per protocol. DON \ Designee will monitor audit tool 5 days a week for 1 month, 3 days a week for 1 month, then weekly for 1 month. Monitored: Executive Director \ Designee, in collaboration with Director of Nursing\Designee will review audits with QA Committee monthly x 3 months and will continue to review audit results monthly for duration of extended timeframe as applicable. Completion Date: 7/8/2022	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified			

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	medication aides. Based on observation, interview, and record review, the facility failed to administer blood glucose tests (accuchecks) in a manner to provide the most accurate reading, failed to properly administer insulin using an insulin pen, and failed to ensure resident's pain was assessed and documented prior to administration of medications for 5 of 5 residents observed during a random medication administration observation (Residents B, C, D, E and G). Findings include: 1. On 6/10/22 at 10:54 a.m., during a random medication pass observation, Qualified Medication Aide (QMA) 4 was observed preparing to check Resident B's blood sugar, in the hallway by the medication cart. QMA 4 removed the accucheck machine from a black zipper bag and cleaned resident B's finger with an alcohol wipe. He then punctured the resident's finger with a lancet and obtained a drop of blood on the test strip. The blood sugar reading was 266. Licensed Practical Nurse (LPN) 3 watched as QMA 4 obtained the sample from the first drop of blood and did not wipe away any alcohol residue from the finger. LPN 3 then checked Resident B's sliding scale insulin orders on the medication administration record (MAR), prepped the injection pen by performing an "air shot" of 2 units (to clear the syringe needle) then dialing the dose, she cleaned the resident's arm with an alcohol swab and administered 6 units of Lispro (fast acting insulin) by pen injection to the resident's arm, in the hallway. Other residents were in the hall and within view of the administration.	R 0241	It is the intent of this facility to ensure that blood glucose tests (accuchecks) are done in a manner to provide the most accurate reading, administer insulin using an insulin pen, and assess and document resident pain prior to administration of medication. Corrective Action: All community Licensed staff in-service was completed on 6/28/2022 on proper administration of blood glucose tests (accuchecks) including disinfection, insulin administration, completion of pain assessments, PRN pain medication and nurse notification. Identification of Other Residents: All residents have the potential to be affected by the deficient practice that have medications administered by facility licensed staff. An Audit of resident medication over the last 30 days will be completed to ensure proper medication administration and\or insulin injection was completed. These audits will be completed by 7/8/2022. Measures: Upon orientation with new staff, training will be provided regarding proper administration of blood glucose tests (accuchecks) including disinfection, insulin administration, completion of pain assessments, PRN pain	07/08/2022

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	2. On 6/10/22 at 11:05 a.m., QMA 4 was observed as he prepared medications for Resident C. Two tablets of Acetaminophen (Tylenol) 500 milligrams (mg) were removed from the blister package and placed in a plastic medication cup. Resident C was seated in the hallway adjacent to the medication cart. LPN 3 was present as QMA 4 checked Resident C's blood sugar. QMA 4 removed the accucheck machine from a black zipper bag and cleaned resident C's finger with an alcohol wipe. He then punctured the resident's finger with a lancet and obtained a drop of blood on the test strip. The blood sugar reading was 267. QMA 4 did not wipe away any alcohol residue from the finger before obtaining the sample on the test strip. LPN 3 checked the orders on the MAR and indicated Resident C was to receive 18 units of scheduled humalog (fast acting insulin) and 3 additional units per sliding scale orders for a blood sugar of 267. The nurse placed a needle on the insulin pen. She lifted Resident C's shirt, cleaned a spot on her abdomen with alcohol and attempted to inject her with the insulin pen. The plunger did not move. LPN 3 indicated, to Resident C, she had forgot to dial up the dose before injecting her. She removed the needle from the pen and discarded it. She then placed a new needle on the syringe and performed an "air shot" of 2 units to clear the syringe needle and dialed up the dose. LPN 3 then recleaned an area on resident C's abdomen with alcohol and injected her with the insulin. 3. On 6/10/22 at 11:14 a.m., QMA 4 was observed as he prepared Resident D's medications, at the medication cart. He removed a scheduled dose of Norco 3/25 (narcotic pain medication) from the		medication and nurse notification. All community licensed staff was educated on 6/28/2022 and agency licensed staff will be educated prior to their scheduled shift. An audit tool will be completed to monitor medication administration\insulin injection. DON \ Designee will monitor audit tool 5 days a week for 1 month, 3 days a week for 1 month, then weekly for 1 month. Monitored: Executive Director \ Designee, in collaboration with Director of Nursing\Designee will review audits with QA Committee monthly x 3 months and will continue to review audit results monthly for duration of extended timeframe as applicable. Completion Date: 7/8/2022	

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	locked narcotic drawer and pushed out the pill from the medication blister packet into a plastic medication cup. He then removed a medication blister pack from the file drawer of resident medications and placed 2 tablets of 4 mg Zocor (for nausea) into the medication cup. He took the medication to the resident's apartment and handed the medication cup with the 3 pills to Resident D. Resident D asked if her nausea medication was in the cup. QMA 4 indicated the cup contained her pain and nausea medication. Resident D swallowed the pills and the QMA exited the apartment. QMA 4 did not ask Resident D about her nausea or pain level when administering the medications. Pain level was not documented on the medication administration record (MAR), or vital sign record. QMA 4 did not notify a licensed nurse before administering a PRN (as needed) medication to the resident. A nurse assessment was not completed. 4. On 6/10/22 at 11:18 a.m., QMA 4 was observed as he prepared Resident E's medications, at the medication cart. He removed a scheduled dose of Oxycodone-Acetaminophen 10/325 (narcotic pain medication) from the medication cart and placed it into the plastic medication cup, from a blister pack. QMA 4 took the medication to Resident E's apartment and administered it. QMA 4 did not inquire about the resident's pain level or document a pain level in the vital sign record or on the MAR. 5. On 6/10/22 at 11:26 a.m., QMA 4 prepared Resident G's medications from the orders on the MAR. He removed a vision shield vitamin from a bottle and placed it in a plastic medication cup. He then took a scheduled tramadol 50 mg tablet from a blister pack (in narcotic drawer) and placed it in			

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		A. BUILDING 00 B. WING	06/10/2022

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	the plastic medication cup. QMA 4 located Resident G in the dining room, having lunch. He administered the medication to Resident G without asking about his pain level. A pain level was not documented on the vital sign record or on the MAR. On 6/10/22 at 12:50 p.m., the Administrator (ADM) indicated the facility had no policy related to QMAs administering PRN medications. They followed the state rules. There was no glucometer policy. They followed a skills check off (copy not provided) for proper procedure. On 6/10/22 at 1:40 p.m., during an interview, the Director of Nursing (DON) indicated when an accucheck was performed, the first drop of blood should have been wiped off before the sample was obtained. QMAs were required to contact the nurse before giving any PRN medication. The nurse needed to assess the resident. A pain level should have been assessed and followed up when a pain medication was given. She did not believe there was a place on the MAR for it to have been recorded. These were standards of practice. On 6/10/22 at 12:50 p.m., the ADM provided a current policy, prepared 5/21/18 and reviewed 5/20/20, titled "Williams Bros Long Term Care Pharmacy." This policy indicated "...In the event current federal and state regulations are updated or found to be more strict/current regulations should be followed and thus, supercede the less strict guidelines...Medications can not be administered in public areas such dining rooms, activity rooms or hallways...Documentation...PRN medication administration: Date, time, and route of administration. Reason or symptoms for administration. Follow-up results of prn medication(s) administration. Initials or electronic			

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	signature of licensed personal that administered medication...." On 6/10/22 at 2:38 p.m., the Administrator (ADM) indicated there was no facility policy on assessments and/or regularly scheduled evaluations, but it was her expectation that the facility followed the state regulations to complete evaluations at least on a semi-annual basis, which should include the residents' ability self-administer medications or not. This deficiency was cited on 4/1/22. The facility failed to implement a systemic plan of correction to prevent recurrence.			
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on observation, interview and record review, the facility failed to obtain licensed an authorization and assessment from a licensed nurse before administering a PRN (as needed) medication for nausea for 1 of 6 residents reviewed for medication administration (Resident D). Findings include: On 6/10/22 at 11:10 a.m., during a medication	R 0246	It is the intent of this facility to ensure that prior to administration of a PRN medication, authorization\notification of a licensed nurse and assessment is completed. Corrective Action: All community Licensed staff in-service was completed on 6/28/2022 on PRN Medication and proper notification and assessment by a licensed nurse.	07/08/2022

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	observation, Resident D opened her apartment door and called out to Qualified Medication Aid (QMA) 4, who was standing down the hall at the medication cart. She indicated she needed her nausea pill with her pain medication. QMA 4 indicated he would bring it to her. On 6/10/22 at 11:14 a.m., QMA 4 was observed as he prepared Resident D's medications, at the medication cart. He removed a scheduled dose of Norco 3/25 (pain medication) from the locked narcotic drawer and pushed out the pill from the medication blister packet into a plastic medication cup. He then removed a medication blister pack from the file drawer of resident medications and placed 2 tablets of 4 mg Zocor (for nausea) into the medication cup. He took the medication to the resident's apartment and handed the medication cup with the 3 pills to Resident D. Resident D asked if her nausea medication was in the cup. QMA 4 indicated the cup contained her pain and nausea medication. Resident D swallowed the pills and the QMA exited the apartment. QMA 4 did not ask Resident D about her nausea or pain level when administering the medications. Pain level was not documented on the medication administration record (MAR). QMA 4 did not notify a licensed nurse before administering a PRN (as needed) medication to the resident. A nurse assessment was not completed. On 6/10/22 at 1:40 p.m., during an interview, the Director of Nursing (DON) indicated QMA's were required to notify the nurse when a PRN medication was requested. The nurse should have assessed the resident. Pain level should have been monitored for all pain medications administered. She did not believe there was a place on the MAR to document it.		Identification of Other Residents: All residents have the potential to be affected by the deficient practice that have PRN medications administered by facility licensed staff. An Audit of resident medication over the last 30 days will be completed to ensure proper PRN medication administration and\or documentation\notification was completed. These audits will be completed by 7/8/2022. Measures: Upon orientation with new staff, training will be provided regarding PRN Medication and proper notification and assessment by a licensed nurse. All community licensed staff was educated on 6/28/2022 and agency licensed staff will be educated prior to their scheduled shift. An audit tool will be completed to monitor PRN Medication\assessment\notification. DON \ Designee will monitor audit tool 5 days a week for 1 month, 3 days a week for 1 month, then weekly for 1 month. Monitored: Executive Director \ Designee, in collaboration with Director of Nursing\Designee will review audits with QA Committee monthly x 3 months and will continue to review audit results monthly for duration of extended timeframe as applicable. Completion Date: 7/8/2022	

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	On 6/10/22 at 12:50 p.m., the Administrator (ADM) indicated the facility had no policy related to QMAs administering PRN medications. They followed the state rules. On 6/10/22 at 12:50 p.m., the ADM provided a current policy, prepared 5/21/18 and reviewed 5/20/20, titled, "Williams Bros Long Term Care Pharmacy." This policy indicated "...In the event current federal and state regulations are updated or found to be more strict/current regulations should be followed and thus, supercede the less strict guidelines...Documentation...PRN medication administration: Date, time, and route of administration. Reason or symptoms for administration. Follow-up results of prn medication(s) administration. Initials or electronic signature of licensed personal that administered medication...."			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on observation, interview, and record review, the facility failed to ensure that medications were properly stored in resident's rooms to keep them secure from other residents for 4 of 4 randomly observed for medication storage (Residents H, K, J, and L). Findings include: 1. On 6/10/22 at 9:30 a.m., Resident H was observed in her room. There were two bottles of medication on top of her microwave in the kitchenette. She indicated she only took two	R 0295	It is the intent of this facility to ensure that medications are properly stored in residents' rooms to keep them secure from other residents. Corrective Action: All community Licensed staff in-service will be completed by 7/5/2022 on properly storing medications. A special Resident Meeting is being held on 7/6/2022 to educate on properly storing medication inside resident rooms.	07/08/2022

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	medications daily, so it was pretty easy. She did not recall the names of the medications but knew they were for blood pressure. She had not been told where or how her medication should be stored, they were just always on top of her microwave to make it easier to remember. Resident H indicated she usually pulled her door closed when she left the room but did not always lock the door. On 6/10/22 at 1:15 p.m., Resident H's medical record was reviewed. She had current active diagnoses which included, but were not limited to, Hypertension (HTN, high blood pressure). Her current physician orders for Amlodipine and Atenolol (both medications treat high blood pressure). She had 4 additional prescriptions for, Caltrate (a calcium supplement), Aspirin 81, Alendronate (a medication used to help treat osteoarthritis) and docusate (a stool softener). 2. On 6/10/22 at 9:38 a.m., Resident K's door was observed opened. She was asleep in her bed but woke easily to a knock. Upon entrance into her a room, a prescription bottle was noted to be left on a table beside her recliner chair. Inside the bottle, there was a glass vile of Cyanocobalamin (an injectable B-12 supplement). Resident K indicated the nurse must have forgotten it. On 6/10/22 at 1:20 p.m., Resident K's medical record was reviewed. She had current active diagnoses which included, but were not limited to, edema, asthma, incomplete paraplegia at the 1st/4th/5th cervical vertebra, and diabetes mellitus. 3. On 6/10/22 at 9:56 a.m., Resident J was observed in his room. His room was cluttered with personal		Identification of Other Residents: All residents have the potential to be affected by the deficient practice that self administer medications. An Audit of resident who self medicate over the last 30 days will be completed to ensure proper medication storage. These audits will be completed by 7/8/2022. Measures: Upon orientation with new staff and resident move-ins, training will be provided regarding proper medication storage inside resident rooms. All community licensed staff will be educated by 7/5/2022 and agency licensed staff will be educated prior to their scheduled shift. An audit tool will be completed to monitor proper medication storage. DON \ Designee will monitor audit tool 5 days a week for 1 month, 3 days a week for 1 month, then weekly for 1 month. Monitored: Executive Director \ Designee, in collaboration with Director of Nursing\Designee will review audits with QA Committee monthly x 3 months and will continue to review audit results monthly for duration of extended timeframe as applicable. Completion Date: 7/8/2022	

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	items which included but were not limited to various prescription and over the counter medications/vitamins: a. spiriva Respimat (a bronchodilator medication used to help treat symptoms of Chronic Obstructive Pulmonary Disease [COPD]) b. fluticasone propionate nasal spray 50 mg (milligrams) (a steroid used to treat nasal allergy symptoms can be used to help prevent asthma attacks) c. wixela propionatea propionate (a prescription medicine used to treat the symptoms of Asthma and COPD). d. salmeterol inhalation powder (a slow-acting bronchodilator that comes as a dry powder to inhale by mouth using a specially designed inhaler. When salmeterol is used to treat asthma or COPD) e. qunol ultra coq10 (FDA [Food and Drug Administration] unapproved an over-the-counter [OTC] dietary supplement used to help replenish the supply of CoQ10 in patients who are deficient) f. vitamin D3 (an OTC supplement) g. equate allergy relief (a generic antihistamine used to treat seasonal allergies) h. pramipexole dihydrochloride (a prescription drug used to treat Parkinson's disease) At this time, Resident J indicated he rarely closed his door because a lot of residents came and went to help themselves to the snacks, he purchased for them. He used to own a restaurant and was "in the business of customer service," so he was happy to share anything he had with his friends. On 6/10/22 at 1:30 p.m., Resident J's medical record was reviewed. He had current diagnoses which included but were not limited to, depression, COPD (chronic obstructive pulmonary disease) and chronic back pain.			

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	His physician order set did not include or indicated the use of the following items which were observed in his room: a. salmeterol inhalation powder (a slow-acting bronchodilator that comes as a dry powder to inhale by mouth using a specially designed inhaler. When salmeterol is used to treat asthma or COPD) b. qunol ultra coq10 (FDA [Food and Drug Administration] unapproved an over-the-counter [OTC] dietary supplement used to help replenish the supply of CoQ10 in patients who are deficient) c. vitamin D3 (an OTC supplement) d. equate allergy relief (a generic antihistamine used to treat seasonal allergies) e. pramipexole dihydrochloride (a prescription drug used to treat Parkinson's disease) 4. On 6/10/22 at 10:35 a.m., Resident L's apartment door was open, and she was not there. A moment later she was observed as she returned from the laundry room with a basket of clothes on her walker. Resident L indicated she always left her door open because there was nothing to steal. A bottle of Tums (an OTC anti-acid) was observed on an end-table beside her couch. She indicated she took those whenever she needed to for heart burn. On 6/10/22 at 1:25 p.m., Resident L's medical record was reviewed. She had active diagnoses which included, but were not limited to dementia, diabetes mellitus and HTN. Her current physician order set did not include an order for Tums. During an interview on 6/10/22 at 1:38 p.m., the Director of Nursing (DON) indicated residents that could self-administer their medications			

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	should keep their medications in an organized and central location, as well as have orders or at least let nursing staff know what was being kept in their rooms. On 6/10/22 at 2:00 p.m., the Administrator (ADM) provided a copy of current facility policy titled, "Self Administration of Medications," revised 5/20/20. The policy indicated, "... each resident is offered the opportunity to self-administer his or her medication during the routine assessments of the facilities interdisciplinary team ... a further assessment of the safety of bedside medications storage is conducted ... the following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if unlockable storage is deemed inappropriate. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the pharmacy ... Medications stored at the decide are reordered in the same manner- as other medications. The nursing staff is responsible for proper rotation of bedside stock and removal of expired, discontinued or recalled medications...."			