STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observation, interview, and record review, the facility failed to ensure 5 alert and oriented residents, (Residents BC, CX, BG, BD and BF) were given the opportunity to participate in their plan of care and make medical decisions for themselves for 5 of 8 residents reviewed for Resident Rights. Findings include: 1. On 9/7/21 at 3:02 p.m., Resident BC was observed during an interview. He sat in a wheelchair between his bed and the window, huddled up next to the window's PTAC (Packaged Terminal Air Conditioner, appliance used for heating and cooling indoors) unit with his arms tucked into his shirt. His head was dropped down and his eyes were closed. He woke to the sound of his name. Resident BC indicated his pain medication had recently been changed from a pill to a liquid and he was upset about it. He was not notified of the change, one day it was a pill, then the next day they brought a cup of liquid. He tried the liquid form of the medication, but it did not last as long, or help manage his pain level as well as the pill had. He complained about the change to his nurse. The nurse told him to talk to the Nurse Practitioner (NP), but the NP said she would not change it back. At this time, Resident BC's family member entered the room and indicated they were also upset about Resident BC's care because his pain was not controlled. They had both complained about his wounds and pain management, but nothing seemed to help. Resident BC indicated the liquid medication tasted horrible, did not touch his pain like the pills had and because it did not last as long, he could not do as much as he wanted to and stayed in his room more than he liked because he hurt too bad and was too cold to get out. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/8/21 at 9:45 a.m., the NP indicated she found Resident BC as a challenging patient due to his many refusals of wound treatments and other various medication/supplement refusals, for instance he did not want to take a stool softener, because he preferred to manage his own bowels and ostomy care. Recently the biggest issue with him [Resident BC] and several others, had been over the NP's decision to switch the narcotic pain medication from a pill to a liquid. The NP indicated she suspected Resident BC and several other residents, of misusing their narcotic medication so she devised a plan to flush out the problem. She suspected several residents of illegal substance abuse because she saw them in the parking lot with vans and had been told that some residents liked to sit outside of the facility late at night. The NP suspected a couple resident also smoked marijuana but did not have proof and had not ordered drug tests for any of the residents she suspected of illicit drug abuse. The NP came up with the idea of changing the residents pain medications from pill form to liquid form and brought it to the IDT (Interdisciplinary Team) for approval. The NP indicated, I figured whoever fusses with me the most about it was probably the ones selling it or profiting from it. The NP indicated she individually selected 8 residents because they were mobile enough to go outside on their own, and if it was going to be anybody, it was going to be them. During an interview on 9/8/21 at 10:05 a.m., RN 18 indicated she had no suspicions that Resident BC had misused his narcotic medication. He always took it as ordered, never asked for too much, and would swallow his pills with a full cup or two of water. RN 18 indicated she did not know why the NP had changed the resident's medication to liquid, but the all the residents were all upset about it. During an interview on 9/8/21 at 10:10 a.m., Licensed Practical Nurse (LPN) 8 and the Assistant Director of Nursing (ADON) both indicated they had never seen Resident BC pocket his pills (a technique where a pill is tucked in an oral cavity, not swallowed, and spit out at a later time) or misuse his pain medications. They did not understand why the narcotic medication had been changed, or why it had not been changed back after he complained. He had been in more pain since the change and had not been out of his room as much. On 9/8/21 at 4:00 p.m. a record review was completed on Resident BC. He was a young male with current diagnoses which included, but were not limited to, osteomyelitis (is inflammation or swelling that occurs in the bone), unspecified open wound of the lower back, paraplegia (paralysis of the legs and lower body), stage IV pressure ulcer (a wound that involves full-thickness tissue loss with exposed bone, tendon or muscle), and a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). The most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) assessment dated [DATE]. The MDS indicated Resident BC was cognitively intact with a BIMS (brief interview for mental status) score of 15 of 15. He had a physician's order, dated 8/31/21, which changed his previously scheduled order of Oxycodone (a narcotic pain medication) 10 mg (milligrams) every 4 hours for pain, to, Oxycodone 5 mg/ml (milliliters), give 10 ml every 4 hours for pain and d/c (discontinue) tablets when liquid arrived. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident BC had a comprehensive care plan, initiated 5/3/21and revised 9/2/21 (two days after the change), which indicated he had complaints of acute and chronic pain related to his pressure ulcer. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. A nursing progress note, dated 9/2/21 at 7:34 a.m., (two days after the medication change), indicated Resident BC had been informed that the NP/MD (Medical Director) had the right to change medications/orders as prescribed in accordance with the facilities new POC (Plan of Correction). At any time, the provider was able to DC (discontinue) or change a medication should they saw fit. 2. During an interview on 9/8/21 at 2:45 p.m., Resident CX indicated his pain medication had been changed from a pill to a liquid without notification. He indicated the liquid medicine burned his throat and did not work as well or last as long. He had an increase of pain in his hips and when he tried to talk to the NP about it, she told him everyone's medication had been changed and she would not change it back, no discussion. On 9/8/21 at 4:10 p.m. a record review was completed on Resident CX. He was a middle aged male and had current diagnoses which included but were not limited to, low back pain and COPD (chronic obstructive pulmonary disease). The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. The MDS indicated Resident BC was cognitively intact with a BIMS score of 15 of 15. He had a physician's order, dated 8/31/21, which changed his previous order of Hydrocodone-Acetaminophen 5-325 mg, 1 tablet every 6 hours as needed for pain, to, Hydrocodone-Acetaminophen solution 7.5-325 mg/15ml, give every 6 hours as needed for pain. Resident CX had a comprehensive care plan, initiated 6/15/21 and revised 9/2/21 (two days after the medication change), which indicated he had complaints of lower back and left femur pain. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. A nursing progress note, dated 9/2/21 at 7:00 a.m. (two days after the medication change), indicated Resident CX had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. 3. During an interview on 9/8/21 at 12:46 p.m., Resident BG indicated her pain medication had been changed from a pill to a liquid without notification. The NP never came to tell her the medicine was going to be changed or why, it was just changed. When she complained about it and the NP came to talk to her about and explained she would not change it back to pills, that she switched everyone over to the liquid. She told the NP it did not work as well, but the NP declined to change it back. On 9/8/21 at 4:15 p.m. a record review was completed on Resident BG. She was a middle aged female and had diagnoses which included but were not limited to, acute on chronic heart failure, COPD, peripheral vascular disease and chronic kidney disease/stage 4. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. The MDS indicated Resident BG was cognitively intact with a BIMS score of 15 of 15. She had a physician's order, dated 8/31/21, which changed her previous order of Oxycodone-Acetaminophen 5-325 mg, 1 tablet every 4 hours as needed for pain, to, Oxycodone 5mg/5ml every 6 hours as needed for pain. Resident BG had a comprehensive care plan, initiated 4/12/21 and revised 9/2/21 (two days after the change), which indicated she had acute pain. Interventions for this plan of care included, but were not limited to, evaluate pain and vital signs. A nursing progress note, dated 9/2/21 at 7:40 a.m. (two days after the medication change), indicated Resident BG had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. 4. During an interview on 9/8/21 at 11:33 a.m., Resident BD indicated he had a complaint that one of his pain medications had been switched from a pill to a liquid. He was not notified that the medication was going to be changed, and when he tried the new form of medicine it bothered his stomach and messed up his colostomy output, which caused him to be in the bathroom having to clean and adjust it more than usual. He did not know why his medicine was changed, but since it had been changed, he had an increase in his pain and at that time had pain on a scale of 8 out of 10. He indicated he did not want his pills crushed and did not want to be given medicine in a cup like a child. On 9/8/21 at 4:20 p.m. a record review was completed on Resident BD. He was a younger male and had diagnoses which included, but were not limited to, osteomyelitis, paraplegia, and a stage IV pressure ulcer to left buttocks. The most recent comprehensive assessment was an admission MDS assessment dated [DATE]. The MDS indicated Resident BD was cognitively intact with a BIMS score of 15 of 15. He had a physician's order, dated 8/31/21, which changed his previous order of Oxycodone 5 mg, 1 tablet every 4 hours as needed for pain, to, Oxycodone 5mg/5ml every 4 hours as needed for pain and DC tablets with liquid arrived. Resident BD had a comprehensive care plan initiated 6/17/21, revised 9/2/21 (two days after the medication change), which indicated he had complaints of acute/chronic pain related to his wound and general discomfort. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. A nursing progress note, dated 9/2/21 at 7:34 a.m.(two days after the medication change), indicated Resident BG had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 9/8/21 at 12:33 p.m., Resident BF was observed during an interview. He laid in his bed with the lights off and indicated he was in pain which is why he did not get up much. He indicated he had not been told that they were going to change his medication from a pill to a liquid, but he had been in too much pain to care so he just accepted it. He indicated he had current pain on a scale of 7 out of 10. On 9/8/21 at 4:25 p.m. a record review was completed on Resident BF. He was a young male and had active diagnoses that included, but were not limited to protein malnutrition, type I Diabetes, Sickle-Cell trait, (an inherited blood disorder where red blood cells (RBCs) become sickle/crescent shaped. It causes frequent infections, swelling in the hands and legs, pain, severe tiredness, and delayed growth or puberty) psychoactive substance abuse, and major depressive disorder. The most recent comprehensive assessment was a 5-day MDS assessment dated [DATE]. The MDS indicated Resident BD was cognitively intact with a BIMS score of 15 of 15. He had a physician's order dated 8/31/21 which changed his previous order of Oxycodone 5 mg, 1 tablet every 4 hours as needed for pain, to, Oxycodone 5mg/5ml every 4 hours as needed for pain and DC tablets with liquid arrived. Resident BF had a comprehensive care plan, initiated 9/2/21 and revised 9/2/21 (two days after the medication change) which indicated he had complaints of acute/chronic pain. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. A nursing progress note, dated 9/2/21 at 7:05 a.m. (two days after the medication change), indicated Resident BF had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. On 9/8/21 at 10:40 a.m., an interview was conducted with the Executive Director (ED), the Administrator in Training (AIT), the Director of Nursing (DON), the Regional Director of Clinical Operations (RDCO). The AIT indicated she had been made aware of the NP's plan to switch the tablet narcotic medications to liquid. The NP presented the plan to the IDT team as another suggestion for the facilities plan of correction (POC) related to medications that had been left at bedside. The NP assured the IDT team she would order the changes after she spoke with the residents. On 9/8/21 at 12:49 p.m. the DON provided a written witness statement. The statement indicated, I [DON] witnessed a telephone call between [RDOC] and [NP] in regards to switching resident's form of pain medication. [RDOC] asked [NP] if prior to making the change, she in fact discussed the plan with each resident. [NP] stated that she indeed [spoke] with everyone and they were all fine with the changes to be made. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/8/21 at 12:32 p.m., the AIT provided a copy of a witness statement from the Midwest Director of Risk Strategy (MDRS). The statement indicated, [AIT] and I were in the activity room and the NP came in and sat down and asked could she talk to use about something. The NP stated that since [the facility] was in a plan of correction for medications being left at bedside and because the residents kept asking her to increase their pain medication, she thought that it would be a good idea to change the patients medication to liquid form. She thought it would eliminate the potential for pills being left at bedside. Several questions were asked to her such as, Are you going to talk to the residents before you change them? Is there any other options we can look at besides liquid? Is this everyone in the facility or do you just have a group of people? She stated that she was going to talk to the resident prior to changing and explain the process, also that it would be the same dosage and the effectiveness would not change . She also acknowledged that she was going to change the medication for the patients that continuously ask for an increase in mediations. She stated that she didn't know why they were asking but stated, Maybe they are trading pills for drugs. [MDRS] stated do you have proof of that? Has anyone reported that to you? Have you seen that happen? To which the NP stated, No, I don't have any proof and no one has reported it to me, but I know they are probably out there smoking weed. To which [the AIT] asked, Have you seen them smoking weed or smelled it or seen someone that you thought was high? The NP again stated, No I don't have any proof of anything going on, I just thought that since they keep asking for an increase maybe the meds are left on the table or they aren't getting them, so I thought it would help with the tag we got for meds left at bedside. I then stated, We don't have to change their meds just for the tag, but if you talk with the residents and they agree and you think it will help with their pain management you're the provider and if you feel it is best for the patient I guess it will be ok. She questioned us about any additional cost to the facility and [AIT and MDRS] both told her that didn't matter if it was better for the patient. [MDRS] then asked her if she changed it on any residents that were not alert could she call the family and put it in her notes and she agreed. On 9/9/21 at 12:10 p.m., a policy titled, Resident Rights, dated 5/19/2016, was provided by the Regional Director of Clinical Operations (RDCO). She indicated this was the current policy in use by the facility at that time. The policy indicated, It is the policy of this facility to promote resident centered care by protecting and promoting the rights of each resident .Residents have rights and autonomy while in the facility that will be respected. This Federal tag relates to Complaint IN00361831. 3.1-3(a)(1)(C) 3.1-3(n)(2)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43491 Based on observation, interview, and record review, the facility failed to ensure biological waste was cleaned off of a resident's bed (Resident G), a bedside table used by the resident (Resident BA) for meals was kept clean of stains and debris, and a resident's room was cleaned and treated to address foul odors (Resident BA) for 3 of 3 residents observed for environment. Findings include: On 9/7/21 at 9:25 a.m., Resident BA was observed lying in his bed with the lights off. The door to the resident's room had been shut prior to entry. A strong odor of ammonia and other unidentified foul odors was immediately noted upon entry into Resident BA's room. The over-bed table and the table base was caked with spilled and dried debris. Debris was also observed on the resident's floor, throughout the room. The resident indicated he had a urostomy (an opening in the abdominal wall made during a surgery. It re-directs urine away from a bladder is not working as it should) and a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon). During an interview at this time, Resident BA indicated, a lot of time the urostomy leaks or the facility staff spilled it and that was why this room smelled so bad, and most times he smelled so bad. The facility staff never cleaned the room. During an interview on 9/7/21 at 10:57 a.m., Housekeeper 35 indicated he was the only housekeeper for that side of the facility. He had about 30 resident rooms assigned to him. He could usually get to everything he had been told to do. He had already finished the front rooms, including Resident BA's room which had been observed that same day still with visible debris on the furniture surfaces and floor, and with a notable strong odor throughout the room. On 9/7/21 at 11:12 a.m., Resident G was observed and interviewed in his room. When asked how often the staff cleaned his mattress, Resident G chuckled and said that was a joke. He pulled his sheet back and indicated he had a colostomy and when it leaked, or if they did not seal it right, it leaked and spilled over the mattress. At that time, a large area of brown and yellow stains was observed under the resident and on the mattress. He indicated the facility staff tried to put a sheet down, but that did not work. The staff always told him there was no way to clean the mattress. On 9/8/21 at 9:04 a.m., Resident G was observed lying in his bed. The resident's bed was observed still stained as the day before. During an interview on 9/8/21 at 10:42 a.m., Housekeeper 32 indicated each resident's room was cleaned daily. All of the furniture and surfaces were cleaned top to bottom, with the floors cleaned last. The bedside tables should be wiped down and sanitized, which included the table base. If a resident was out of bed, the mattress was sprayed with a disinfectant and wiped down. If a mattress was damaged or soiled beyond what could be wiped off, a new mattress could be obtained that same day. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/8/21 at 10:56 a.m., Certified Nurse's Aide (CNA) 33 indicated, resident rooms were cleaned by housekeeping every day. The bathrooms were cleaned, all surfaces and furniture were wiped down, the trash was taken out, and the floors were swept and mopped. If a mattress got soiled, nursing staff could get the disinfectant spray from the housekeeping closet and clean it themselves. If the mattress was beyond cleaning, staff should call maintenance and get a new mattress. There was no difference in cleaning a regular mattress and a low air loss (used for both the prevention and treatment of pressure wounds) or specialty mattress. The cleaning supplies were always available, so it was not hard to do. On 9/8/21 at 4:00 p.m., Resident BA was observed lying in bed. The door to his room had been shut prior to entry. The room still had a strong noxious odor that was noted immediately upon entry to the resident's room. Resident BA indicated, the janitor came in and swept up real quick, but was in and out so fast the resident did not see that anything was cleaned, and the room still smelled bad. On 9/8/21 at 4:03 p.m., Resident G was observed lying in bed. He indicated he did not feel well that day and did not want to get out of bed, so staff just put another sheet on top of the layer of sheets that covered the stained area on his mattress. Resident G indicated he had spoken with Licensed Practical Nurse (LPN) 15 about the mattress being dirty and was told by LPN 15 there was no way to clean it other than what they were doing by just putting clean sheets over the soiled mattress. During an interview on 9/8/21 at 4:06 p.m., Housekeeper 35 indicated he went to Resident BA's room that morning. Resident BA's room always smelled like that. He went into the resident's room to mop, sweep, and disinfect. That was all he could do, but it always smelled bad, and he tried to get in and get out as fast as he could. On 9/9/21 at 9:07 a.m., Resident G was observed lying in bed. The mattress under the resident was stained with brown and light-yellow liquid. The stained area was longer than 1 foot in length and wider than 6 inches. Resident G indicated the spot has been there more than two weeks, it was dried now. On 9/9/21 at 11:05 a.m., Resident G was observed with the Administrator in Training (AIT). The resident indicated he was feeling much better. Resident G indicated the nursing aids did not take their time to empty his ostomy bag neatly and it spilled, but they did not get him up to clean him all the way, so it stained and smelled. Resident G pulled his sheet back. The AIT observed Resident G's mattress and indicated it was beyond cleaning and she was going to order the resident a new mattress herself. During an interview on 9/9/21 at 11:30 a.m., the AIT indicated Resident G's mattress had been replaced twice since his admission to the facility. The staff needed to be educated on how to prevent the mattress from continually becoming soiled. On 9/9/21 at 11:34 a.m., Resident BA was observed lying in bed. The door to the resident's room had been shut prior to entry. Upon entry, the resident's room was still notable for a strong foul odor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/9/21 at 1:22 p.m., the Executive Director (ED) indicated there was no specific facility policy related to maintaining a clean, comfortable, homelike environment for the residents, but the process was that nursing would clean as needed. For bodily fluid it would need to be cleaned immediately by nursing and housekeeping would come back through for disinfecting. During an interview on 9/10/21 at 12:15 p.m. the District Manager (DM) indicated resident rooms were cleaned once a day. Housekeeping staff went back and did pick- ups as needed, for things like spills. Housekeeping staff rounded after lunch and at end of the day to make sure there was no debris or things on the floor. Daily cleaning included, but was not limited to, emptying trash, high dusting (dusting in high or hard-to-reach places), dusting and wiping down the bed frame, sanitizing the mattress if the room is empty, clean the bathroom, sanitizing all handles, sinks, doorknobs, and other high touch areas; sweep and mop the floor. Beds were sanitized with peroxide cleaner, wiped down top to bottom, and on both sides. The low air loss and specialty mattresses took the same cleaning. Bedside tabletops and bases were included in room cleaning. On 9/10/21 at 1:00 p.m., the AIT provided a document titled, Federal Resident Rights & Facility Responsibilities. She indicated this was the current document in use by the facility at that time. The document indicated, .The resident has a right to a dignified existence .in an environment that promotes maintenance or enhancement of his or her quality of life .The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to . Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; (3) Bed & Bath Linens. Clean bed and bath linens that are in good condition This Federal tag relates to Complaint IN00361831. 3.1-19(a)(4) 3.1-19(f)(5) 3.1-19(m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38768 Based on observation, interview and record review, the facility failed to ensure pain management was provided to 8 residents, (Residents, BC, CX, BG, BD, BF, AH, CR and CT) consistent with professional standards of practice to relieve their pain and honor their residents' preferences for 8 of 8 residents reviewed for pain management. The immediate jeopardy began on 8/31/21 when the Nurse Practitioner (NP) changed the 8 alert and oriented residents' narcotic pain medications. Residents BC, CX, BG, BD, BF, CR and CT were not notified prior to the change in their medication and therefore, did not have the opportunity to participate in making decisions about their medical care. Resident CR requested to go to the emergency room (ER) for increased pain, Resident CT left AMA (against medical advice) and all 6 remaining residents complained of increased pain and side effects due to the medication change. Residents BC, CX, BG and BD indicated the medication change created side effects which interrupted their daily routines and decreased their ability to participate in their activities of daily living (ADLs). The Executive Director (ED), the Administrator in Training (AIT) and the Director of Nursing (DON) were notified of the immediate jeopardy on 9/9/21 at 4:54 p.m. The immediate jeopardy was removed on 9/10/20, but noncompliance remained at a lower scope and severity of pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: 1. On 9/7/21 at 3:02 p.m., Resident BC was observed during an interview. He sat in a wheelchair between his bed and the window, huddled up next to the window's PTAC (Packaged Terminal Air Conditioner, appliance used for heating and cooling indoors) unit with his arms tucked into his shirt. His head dropped and his eyes were closed. He woke to the sound of his name. Resident BC indicated his pain medication had recently been changed from a pill to a liquid and he was upset about it. He was not notified of the change, one day it was a pill, then the next day they brought a cup of liquid. He tried the liquid form of the medication, but it did not last as long, or help manage his pain level as well as the pill had. He complained about the change to his nurse. The nurse told him to talk to the NP, but the NP said she would not change it back. At this time, Resident BC's family member entered the room and indicated they were also upset about Resident BC's care because his pain was not controlled. They had both complained about his wounds and pain management, but nothing seemed to help. Resident BC indicated the liquid medication tasted horrible, did not touch his pain like the pills had and because it did not last as long, he could not do as much as he wanted to and stayed in his room more than he liked because he hurt too bad and was too cold to get out. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/8/21 at 9:10 a.m., Resident BC was observed during an interview. He laid in bed and indicated he was in excruciating pain. He pressed on his forehead and temples, his face was grimaced, and he winced in pain. Resident BC indicated, and the Certified Nursing Assistant (CNA) had just finished helping him get cleaned up and positioned which caused an increase in his pain because of the wound on his bottom. Please, I need pain medication, it's all I ask! At this time, the nurse was notified of his pain. Registered Nurse (RN) 18 entered Resident BC's room with his morning medications in a small plastic medication cup. He indicated he was in pain and asked if his pain pill was in the cup. RN 18 indicated no because the order had been changed to a liquid. Resident BC indicated it was nasty and did not work, he wanted his pain pill back, but he would try the liquid again. When RN 18 returned, she indicated Resident BC was out of his liquid narcotic pain medication and when Resident BC asked how that could be if he never took it? RN 18 did not know why his liquid pain medication was out, but she would go ask the NP if she could pull the medication from the EDK (Emergency Drug Kit). RN 18 asked what his pain level was on a scale of 1-10, 10 being the worst. Resident BC indicated, 1000! I don't know, it's just really bad. During an interview on 9/8/21 at 9:45 a.m., the NP indicated she found Resident BC as a challenging patient due to his many refusals of wound treatments and other various medication/supplement refusals, for instance he did not want to take a stool softener, because he preferred to manage his own bowels and ostomy care. Recently the biggest issue with Resident BC and several others, had been over the NP's decision to switch the narcotic pain medication from a pill to a liquid. She suspected Resident BC and several other residents, of misusing their narcotic medication so she devised a plan to flush out the problem. She suspected several residents of illegal substance abuse because she saw them in the parking lot with vans and had been told that some residents liked to sit outside of the facility late at night. The NP indicated she suspected a couple residents also smoked marijuana but did not have proof and had not ordered drug tests for any of the residents she suspected of illicit drug abuse. The NP came up with the idea of changing their pain medications from pill form to liquid form and brought it to the IDT (Interdisciplinary Team) for approval. The NP indicated, I figured whoever fusses with me the most about it was probably the ones selling it or profiting from it. The NP indicated she individually selected 8 residents because they were mobile enough to go outside on their own, and if it was going to be anybody, it was going to be them. The NP indicated of the 8 residents, Resident CR sent himself to the hospital for uncontrolled pain last week, Resident CT went LOA (Leave of Absence) and never came back. Resident BD had last complained on Friday, but she had not planned to see him again since he was going to discharge soon anyway. Resident BC complained about it the very first day, but she had not seen him out of his room and had not gone to see him either. Resident BC had complained the most about the change. He was considered an incomplete quad (Incomplete paraplegia means that the injury has not completely severed your spinal cord and some neural circuits between the brain and body still exist) and did have some sensation in his lower extremities, so he probably did have some discomfort and pain due to his wound, but if he was in that much pain, he should take the liquid medication. During an interview on 9/8/21 at 10:05 a.m., RN 18 indicated she had no suspicions that Resident BC had misused his narcotic medication. He always took it as ordered, never asked for too much, and would swallow his pills with a full cup or two of water. Yes, he was non-complaint with his wound treatments a lot of the time, but he was fully alert, oriented, and aware of the consequences. RN 18 believed his pain was legitimate, and he had complained of more pain, more frequently since the change in his medication. He had been staying in his room more than usual and that was not like him. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 9/8/21 at 10:10 a.m., Licensed Practical Nurse (LPN) 8 and Assistant Director of Nursing (ADON) both indicated they had never seen Resident BC pocket his pills (a technique where a pill is tucked in an oral cavity, not swallowed, and spit out at a later time) or misuse his pain medications. They did not understand why the narcotic medication had been changed, or why it had not been changed back after he complained. He had been in more pain since the change and had not been out of his room as much. On 9/8/21 at 4:00 p.m. a record review was completed on Resident BC. He was a young male, with current diagnoses which included, but were not limited to, Osteomyelitis (is inflammation or swelling that occurs in the bone), unspecified open wound of the lower back, paraplegia (paralysis of the legs and lower body), stage IV pressure ulcer, and a colostomy. The most recent comprehensive assessment was a quarterly Minimum Data Set (MDS) assessment dated [DATE]. The MDS indicated Resident BC was cognitively intact with a BIMS (brief interview for mental status) score of 15 of 15. He had a physician's order dated 8/31/21 which changed his previously scheduled order of Oxycodone (a narcotic pain medication) 10 mg (milligrams) every 4 hours for pain, to Oxycodone 5 mg/ml (milliliters), give 10 ml every 4 hours for pain and d/c (discontinue) tablets when liquid arrived. Resident BC's MAR (Medication Regimen Review) indicated he needed to be monitored for signs/symptoms of pain every shift. The week before his medication was changed, indicated he only complained of pain for 8 of 24 shift: 8/24: day shift= 0, evening shift= 0, night shift= 5 8/25: day shift= 0, evening shift= 0, night shift= not recorded 8/26: day shift= 10, evening shift= 1, night shift= 0 8/27: day shift= 0, evening shift= NA, night shift= 0 8/28: day shift= 0, evening shift= 0, night shift= 7 8/29: day shift= 2, evening shift= 0, night shift= 6 8/30: day shift= 2, evening shift= 0, night shift= 0 8/31: day shift= 9, evening shift= 0, night shift= 0 The week after his medication was changed, indicated he complained of pain for 15 of 27 shifts: 9/1: day shift= 0, evening shift= 0, night shift= 0 9/2: day shift= 10, evening shift= 0, night shift= 5 9/3: day shift= 5, evening shift= not recorded, night shift= 8 (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/4: day shift= 8, evening shift= 5, night shift= 0 9/5: day shift= 5, evening shift= not recorded, night shift= 4 9/6: day shift= 5, evening shift= 0, night shift= 0 9/7: day shift= 0, evening shift= 0, night shift= 0 9/8: day shift= 10, evening shift= 6, night shift= 8 Resident BC had a comprehensive care plan, initiated 5/3/21 and revised 9/2/21, which indicated he had complaints of acute and chronic pain related to his pressure ulcer. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. A nursing progress note, dated 9/2/21 at 7:34 a.m., indicated Resident BC had been informed that the NP/MD (Medical Director) had the right to change medications/orders as prescribed in accordance with the facilities new POC (Plan of Correction). At any time, the provider was able to DC (discontinue) or change a medication should they saw fit. A nursing progress note dated 9/3/21 at 2:54 p.m., indicated Resident BC took his scheduled medication, but refused his pain medication. On 9/9/21 at 4:25 p.m., Resident BC's Medication Administration Record (MAR) was reviewed and compared to the charting on the narcotic sheet for accuracy. a. On 9/2/21 at midnight, LPN 19, charted on the narcotic sheet that Resident BC refused his oxycodone 10 mLs of pain medication. On the MAR, on the same date and time, she indicated Resident BC took his oxycodone medication 10 mLs. b. On 9/2/21 at 4:00 a.m., LPN 19, charted on the narcotic sheet that Resident BC refused his oxycodone 10 mLs. On the MAR, on the same date and time, she indicated Resident BC took his oxycodone medication 10 mLs. c. On 9/3/21 at 4:00 p.m., LPN 20 charted on the narcotic sheet that Resident BC took his oxycodone 10 mLs. On the MAR, on the same date and time, she indicated Resident BC refused his oxycodone medication 10 mLs. d. On 9/4/21 at 8:00 p.m., Temp Med Tech (TMT) 21 charted on the narcotic sheet that Resident BC took his oxycodone 10 mLs. On the MAR, on the same date and time, she indicated Resident BC refused his oxycodone 10 mLs. On 9/9/21 at 11:40 a.m., Resident BC was observed. He sat upright in his wheelchair in his bathroom as prepared his ostomy supplies. His eyes were bright, and he indicated he was feeling a lot better. He had received a pain pill the night before and it worked. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/9/21 at 1:36 p.m., Resident BC was observed as he returned in from sitting outside, and indicated it was the first time he had been outside in a while. 2. During an interview on 9/8/21 at 2:45 p.m., Resident CX indicated his pain medication had been changed from a pill to a liquid without notification. He indicated the liquid medicine burned his throat and did not work as well or last as long. He indicated he had an increase of pain in his hips and when he tried to talk to the NP about it, she told him everyone's medication had been changed and she would not change it back, no discussion. On 9/8/21 at 4:10 p.m. a record review was completed on Resident CX. He was a middle aged male and had current diagnoses which included but were not limited to, low back pain and COPD (chronic obstructive pulmonary disease). The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. The MDS indicated Resident BC was cognitively intact with a BIMS score of 15 of 15. He had a physician's order, dated 8/31/21, which changed his previously scheduled order of Percocet 5-325 (Oxycodone-Acetaminophen- a narcotic pain medication) mg, 1 tablet every 6 hours for pain, to Hydrocodone-Acetaminophen solution 7.5-325 mg/ml, give every 6 hours as needed for pain. Resident CX's MAR indicated he needed to be monitored for signs/symptoms of pain every shift. The week before his pain medicine was changed, there were no recorded pain levels. The week after his medication was changed, indicated he complained of pain for 10 of 21 shifts: 9/1: day shift= not recorded, evening shift= not recorded, night shift= not recorded 9/2: day shift= not recorded, evening shift= 0, night shift= 6 9/3: day shift= 0, evening shift= 7, night shift= 6 9/4: day shift= 6, evening shift= 0, night shift= 6 9/5: day shift= 6, evening shift= 3, night shift= 0 9/6: day shift= 0, evening shift= 0, night shift= 0 9/7: day shift= 3, evening shift= 8, night shift= 1 A vital sign report graph for pain level indicated, after 8/31/21 Resident CX reported pain increased to a level 8 out of 10 on 9/5, 9/6, 9/7 and 9/8. Resident CX had a comprehensive care plan, initiated 6/15/21 and revised 9/2/21, which indicated he had complaints of lower back and left femur pain. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing progress note, dated 9/2/21 at 7:00 a.m., indicated Resident CX had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. A nursing progress note, dated 9/4/21 at 3:16 p.m., indicated Resident CX was alert, oriented and able to make his needs known. He complained of pain and discomfort in his back. On 9/8/21 at 3:58 p.m., Resident CX's hydrocodone apap (for severe pain relief) 7.5-325 mg bottle was observed with LPN 22 for the quantity inside. It was 53 mL. The order indicated give 15 mL by mouth every 6 hours as needed (PRN) for pain. The narcotic sheet was observed to be inaccurate indicating 38 mL in the bottle. On 9/9/21 at 4:20 p.m., the Director of Nursing (DON) provided updated copy of Resident CX's narcotic sheet. After the quantity was identified as 38 mL on 9/8/21 at 3:58 p.m., the distribution of the remaining medication was as follows: a. On 9/8/21 at 1636 (4:36 p.m.), 15 mL were provided for the resident, with 23 mL remaining in the bottle. b. On 9/8/21 at 2145 (9:46 p.m.), 15 mL were provided for the resident with 8 mL remaining. These doses were not 6 hours apart. c. On 9/9/21 at midnight, an illegible name indicated the correct count remaining in the bottle was 20 mL. d. On 9/9/21 at 0630 (6:30 a.m.), 15 mL were given, leaving 5 mL in the bottle. e. On 9/9/21 at 7:00 a.m., an illegible name indicated the count was correct again with 10 mLs still in the bottle. f. On 9/9/21 at 11:21 a.m., 10 mL were given, leaving 0 mL in the bottle. On 9/10/21 at 11:41 a.m., Resident CX's MAR was reviewed and compared to the charting on the narcotic sheet for accuracy: a. On 9/1/21 at 6:00 a.m., LPN 23 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. b. On 9/2/21 at 12:30 a.m., LPN charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. c. On 9/2/21 at 12:00 p.m., the Assistant Director of Nursing (ADON) charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. d. On 9/5/21 at 8:00 p.m., LPN 7 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	e. On 9/7/21 at 2:40 a.m., LPN 23 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. f. On 9/7/21 at 11:00 p.m., LPN 10 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. g. On 9/8/21 at 6:30 a.m., LPN 23 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. On 9/9/21 at 4:30 p.m., the AIT indicated the narcotic charting should have been accurate and all narcotic medication should have been accounted for in the charting. 3. During an interview on 9/8/21 at 12:46 p.m., Resident BG indicated her pain medication had been changed from a pill to a liquid without notification. She indicated it did not work and that was why she was still laying in her bed. She indicated she was in pain at that time and did not know if she wanted to get out of bed. The liquid medicine gave her the jerks. The NP never came to tell her the medicine was going to be changed or why, it was just changed. When she complained about it and the NP came to talk to her about and explained she would not change it back to pills, that she switched everyone over to the liquid. She told the NP it did not work as well, but the NP declined to change it back. Resident BG indicated she did not get up as much and did not sit outside like she wanted to. On 9/8/21 at 2:50 p.m., Resident BG was observed in her wheelchair in the hallway. She was stopped and rested her head in her hands with her eyes closed. At this time, she indicated, she left therapy early because her pain broke through and she needed to go ask the nurse for more medicine. On 9/8/21 at 4:15 p.m. a record review was completed on Resident BG. She was a middle aged female and had diagnoses which included but were not limited to, acute on chronic heart failure, COPD, peripheral vascular disease, and chronic kidney disease/stage 4. The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. The MDS indicated Resident BG was cognitively intact with a BIMS score of 15 of 15. She had a physician's order, dated 8/31/21, which changed his previous order of Oxycodone-Acetaminophen 5-325 mg, 1 tablet every 4 hours as needed for pain, to, Oxycodone 5mg/ml every 6 hours as needed for pain. Resident BG's MAR indicated she needed to be monitored for signs/symptoms of pain every shift. The week before his pain medicine was changed, there were no recorded pain levels. The week after her medication was changed, indicated she complained of pain for 9 of 21 shifts: 9/1: day shift= not recorded, evening shift= not recorded, night shift= not recorded 9/2: day shift= 6, evening shift= 0, night shift= 5 9/3: day shift= 0, evening shift= 0, night shift= 2 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	9/4: day shift= 0, evening shift= 0, night shift= 8 9/5: day shift= 8, evening shift= 4, night shift= 0 9/6: day shift= 0, evening shift= 0, night shift= 7 9/7: day shift= 0, evening shift= 0, night shift= 1 Resident BG had a comprehensive care plan, initiated 4/12/21 and revised 9/2/21, which indicated she had acute pain. Interventions for this plan of care included but were not limited to evaluate pain and vital signs. A nursing progress note, dated 9/2/21 at 7:40 a.m., indicated Resident BG had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. A nursing progress note, dated 9/8/21 at 1:40 p.m., indicated Resident BG stated she had pain but refused her narcotic elixir (liquid medication). Resident BG requested the pill form. 4. During an interview on 9/8/21 at 11:33 a.m., Resident BD indicated he had a complaint that one of his pain medications had been switched from a pill to a liquid. He was not notified that the medication was going to be changed, and when he tried the new form of medicine it bothered his stomach and messed up his colostomy output, which caused him to be in the bathroom having to clean and adjust it more than usual. He did not know why his medicine was changed, but since it had been changed, he had an increase in his pain and at that time had pain on a scale of 8 out of 10. He indicated he did not want his pills crushed and did not want to be given medicine in a cup like a child. On 9/8/21 at 4:20 p.m. a record review was completed on Resident BD. He was a younger male and had diagnoses which included, but were not limited to, osteomyelitis, paraplegia, and a stage IV pressure ulcer to left buttocks. The most recent comprehensive assessment was an admission MDS assessment dated [DATE]. The MDS indicated Resident BD was cognitively intact with a BIMS score of 15 of 15. He had a physician's order dated 8/31/21 which changed his previous order of Oxycodone 5 mg, 1 tablet every 4 hours as needed for pain, to, Oxycodone 5mg/ml every 4 hours as needed for pain and DC tablets with liquid arrived. A review of a vitals sign report graph indicated Resident BD had an increase of intensity of pain in the week following his medication change. The highest level of pain recorded for the week before the change in his medicine was 8/24/21 on the day shift at a level of 8 out of 10. After the medication was changed his pain increased to a 10 out of 10 on 9/7/21. Resident BD had a comprehensive care plan, initiated 6/17/21 and revised 9/2/21, which indicated he had complaints of acute/chronic pain related to his wound and general discomfort. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing progress note dated 9/2/21 at 7:34 a.m., indicated Resident BD had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. 5. On 9/8/21 at 12:33 p.m., Resident BF was observed during an interview. He laid in his bed with the lights off and indicated he was in pain which was why he did not get up much. He indicated he had not been told that they were going to change his medication from a pill to a liquid, but he had been in too much pain to care so he just accepted it. He had current pain on a scale of 7 out of 10. On 9/8/21 at 4:25 p.m. a record review was completed on Resident BF. He was a young male and had active diagnoses that included, but were not limited to protein malnutrition, type I Diabetes, Sickle-Cell trait, psychoactive substance abuse, and major depressive disorder. The most recent comprehensive assessment was a 5-day MDS assessment dated [DATE]. The MDS indicated Resident BD was cognitively intact with a BIMS score of 15 of 15. He had a physician's order dated 8/31/21 which changed his previous order of Oxycodone 5 mg, 1 tablet every 4 hours as needed for pain, to, Oxycodone 5mg/ml every 4 hours as needed for pain and DC tablets with liquid arrived. Resident BF had a comprehensive care plan, initiated 9/2/21 and revised 9/2/21 which indicated he had complaints of acute/chronic pain. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. A nursing progress note, dated 9/2/21 at 7:05 a.m., indicated Resident BF had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. 6. During an interview on 9/8/21 at 2:55 p.m., CNA 30 indicated she had worked with Resident AH since the medication change. Apart from complaints about food, he complained mostly about the medication switch and so did several other residents. During an interview on 9/8/21 at 2:58 p.m., Resident AH was observed. He laid on his side in his bed and indicated he was in pain. Resident AH's medication had been switched from a pill to a liquid, and the NP had come to talk to him about it before the switch. She assured him it was the same strength and would have the same effect for his pain, so he agreed. After trying the liquid medication however, he found that it did not work as well, and he experienced breakthrough pain. When he complained to the NP about the new medication, she indicated she would not change the order back, but that he could try to take Tylenol with it to help. He indicated his pain was in his back and legs on a scale of 7 out of 10 at that time. During an interview on 9/8/21 at 3:00 p.m., LPN 15 indicated he was aware that Resident AH did not like the new pain medication, but he had agreed to try Tylenol with his next dose to see if that helped more. At this time LPN 15 indicated Resident BD had also complained to him and the wound NP about the medication switch during wound round earlier in the week, but LPN told him, Sorry, wrong NP, and referred him to the prescriber NP. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 9/8/21 at 4:30 p.m. a record review was completed on Resident AH. He was a [AGE] year old male with diagnoses that included, but were not limited to, COPD, Myalgia (pain), and osteoarthritis. The most recent comprehensive assessment was a quarterly MDS assessment dated [DATE]. The MDS indicated Resident BD was cognitively intact with a BIMS score of 14 of 15. He had a physician's order dated 8/31/21 which changed his previous order of Percocet 5-325 mg Oxycodone 5 mg, 1 tablet every 6 hours as needed for pain, to, Oxycodone 5mg/ml every 6 hours as needed for pain. Resident AH had a comprehensive care plan initiated 2/22/21, revised 9/2/21 which indicated he had chronic lower pain and reported episodes of pain radiating down his legs. Interventions for this plan of care included, but were not limited to, notifying the medical provider if interventions were unsuccessful, and to monitor for signs/symptoms of side effects and evaluate effectiveness of medications. 7. On 8/9/21 at 4:35 p.m., a closed record review was completed for Resident CR. He was a younger male with diagnoses that included but were not limited to, paraplegia, pressure ulcer of the sacral region and chronic pain due to trauma. A nursing progress note, dated 9/2/21 at 10:15 a.m., indicated Resident CR had a change in condition related to uncontrolled pain. He had a physician's order, dated 8/31/21 which changed his previous order of Oxycodone 15 mg, give 1 tablet 6 times a day for pain, to, Oxycodone 5mg/ml give 15 ml by mouth every 4 hours for pain DC 15 mg tabs when liquid arrives. A nursing progress note, dated 9/2/21 at 7:02 a.m., indicated Resident BF had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. A nursing progress note dated 9/2/21 at 10:18 a.m., indicated Resident CR complained of stomach pain and pain all over and requested to be sent to the ER. A hospital summary report, dated 9/2/21 at 12:19 p.m. indicated Resident CR presented to the ER with a chief complaint of tailbone pain related to a Stage IV pressure ulcer. The report indicated, Resident CR is a [AGE] year old male who presents to the emergency department for evaluation of tailbone pain. Patient with a history of gunshot wound, has residual chronic osteomyelitis in sacral decubitus ulcers. For the past 2-3 days has had increasing pain, drainage noted from these area. Noticed the drainage is green, intermittent . Patient is also concerned regarding his recent care at his subacute rehab facility. States he does not feel they care caring adequately for his chronic wounds . Patient requesting alternative facility placement. 8. O 8/9/21 at 4:40 p.m., a closed record review, was completed for Resident CT. He was a [AGE] year old male with diagnoses to include, but were not limited to, paraplegia, joint stiffness, and weakness. (continued on next page)

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing progress note dated 9/2/21 at 7:05 a.m., indicated Resident CT had been informed that the NP/MD had the right to change medications/orders as prescribed in accordance with the facilities new POC. At any time, the provider was able to DC or change a medication should they saw fit. A nursing progress note dated 9/5/21 at 12:50 a.m., indicated Resident CT was not in his room during midnight checks. He was thought to be LOA (leave of absence) and his listed contact phone number was called. Someone else answered the phone and stated the resident was not with them and would not return to the facility because he had moved out of state. On 9/8/21 at 10:40 a.m., an interview was conducted with the Executive Director (ED), the Administrator in Training (AIT), the Director of Nursing (DON), the Regional Director of Clinical Operations. The AIT indicated she had been made aware of the NP's plan to switch the tablet narcotic medications to liquid. The NP presented the plan to the IDT team as another suggestion for the facilities POC (plan of correction) related to medications that had been left at bedside. The NP assured the IDT team she would order the changes after she spoke with the residents. The ED, AIT, and DON all indicated they had not been made aware of any suspicions the NP may have had about resident's misuse of their medications. The Regional Director of Clinical Operations indicated, she found out about the change in medication a couple of days later and questioned the NP about the adjustment, and offered other options such as mouth checks, or room checks, but the NP declined and indicated she was the provider and could make the changes as she wanted. The Regional Director of Clinical Operations had never witnessed, heard, or seen any suspicious activities from the residents to suggest they misused their medications. The Regional Director of Clinical Operations questioned the NP further, but still she declined to consider other options. The AIT indicated she started hearing complaints from residents the first day after the change. She saw Resident BC and CR outside and when she asked them to move to a smoking area, they began to complain about the medication being switched from a pill to a liquid. She assured the Residents she would talk to the NP about their concerns. When she did, the NP continued to decline the request to consider other options. The Regional Director of Clinical Operations indicated the NP absolutely should have spoken with any alert and oriented resident before making changes to their medications and if she suspected illicit drug use, or misuse of the resident's narcotic medications, she should have reported it to the ED so that an investigation could be conducted, or the police could have been called to do a room search. The Regional Director of Clinical Operations indicated there were several other options that could have been considered before making the switch to liquid, for example, the facility could have asked residents [TRUNCATED]

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37981 Based on observation, interview, and record review, the facility failed to provide medications on-time per physician's order for 17 of 105 residents reviewed for on-time medications (Resident K, BK, BL, BG, BP, AX, BQ, C, BZ, Z, CG, BR, CC, BF, CA, CD, and CB); failed to ensure treatments were completed on-time per physician's order for 4 of 4 reviewed for treatments (Resident CK, BV, CB, and CJ), failed to ensure medications were charted when they were given, and not at the end of the shift for 27 of 27 resident reviewed for on-time charting (Resident AH, CQ, DG, DJ, DH, DK, DL, DM, DN, DP, DS, DT, [NAME], DV, DW, DX, [NAME], DZ, EB, EC, EF, EG, EJ, [NAME], EM, EN, and CL); failed to ensure narcotics were documented correctly on the narcotic counting sheet, charted correctly in the resident's Medication Administration Record (MAR), and narcotics were tracked appropriately per facility policy for 4 of 8 residents reviewed for narcotics (Resident BC, CX, AH, and BV). Findings include: 1. On 9/5/21 at 6:40 p.m., Qualified Medical Aide (QMA) 7 indicated the resident medications should have been given an hour before or an hour after the physician order according to the policy of the facility. She was in charge of Heritage Medication Cart 1. She had 7 residents who were late with their 5:00 p.m. medications. Resident K still needed her insulin, and she had four medications for Resident BK. The remainder of the residents she listed as late were Residents BL, BG, BP, and AX. On 9/7/21 at 12:16 p.m., the Administrator in Training (AIT) provided documents of the Medication Administration Record (MAR) for the Heritage residents. The MARs were reviewed: a. Resident K's had 6 late medications: lispro (insulin), brimonidine (for glaucoma), carvedilol (for chest pain), docusate (for constipation), Dorzolamide (for glaucoma), and ticagrelor (blood thinner). b. Resident BK had 2 late medications: Mary's magic mouthwash (treats infections inside the mouth) and buffered aspirin (pain relief). c. Resident BL had 3 late medications: ferrex (supplement), buspirone (for anxiety), and miralax (for constipation). d. Resident BG had 6 late medications: atorvastatin (decreases cholesterol), Klor-con (supplement), Xarelto (blood thinner), carvedilol (for congestive heart failure), furosemide (diuretic), and Symbicort (for congestive obstructive pulmonary disease). e. Resident BP had 4 late medications: Novolog (insulin), Creon (for pancreatitis), aspirin (pain relief), and docusate (for constipation). f. Resident AX had 2 late medications: levetiracetam (seizures), and Nepro (supplement). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/21 at 6:48 p.m., Licensed Practical Nurse (LPN) 8 indicated she was the only nurse in the building with 105 residents, and she was in charge of the Health Medication Cart 1 and Heritage Medication Cart 2. On 9/5/21 at 6:50 p.m., LPN 8 provided access to the MAR for the Health side. The residents who were highlighted in pink (more than one hour after the physician's order to give medications). QMA 9 was in charge of Health Medication Cart 2. The late residents were as follows: a. Resident BQ had one late medication: Coumadin (blood thinner). b. Resident C had 3 late medications: Eliquis (blood thinner), Keppra (for seizures), and carvedilol (hypertension). c. Resident BZ had 2 late medications: benztropine mesylate (for Parkinson's disease) and Lopressor (for hypertension). d. Resident Z had one late medication: potassium chloride (supplement). e. Resident CG had one late medication: metformin. f. Resident BR had one late medication: Entresto (for heart failure). g. Resident CC had one late medication: metformin (lowers blood sugar levels). h. Resident BF had one late medication: adelog (insulin). i. Resident CA had 2 late medications: metformin and gabapentin. j. Resident CD had one late medication: apixaban (blood thinner). k. Resident CB had one late supplement: Ensure. On 9/5/21 at 6:56 p.m., LPN 8 indicated when a resident medication was late, the system highlighted them in pink indicating they have not been done yet. On 9/5/21 at 7:05 p.m., Qualified Medical Aide 9 indicated she was in charge of the Health side medication cart 2. She charted the medications as she gave them and was running behind in administering resident medications. 2. On 9/5/21 at 6:50 p.m., the Treatment Administration Record (TAR) indicated 5 resident treatments were late. The information from the TAR was as follows: a. Resident CK had one late treatment: Apply triamcinolone acetonide cream (for skin inflammation) to buttocks. b. Resident BV had one late treatment: Cleanse right foot with betadine (antiseptic). c. Resident CB had one late treatment: Apply diclofenac (pain relief) 1% to knees. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Resident CJ had one late treatment: Cleanse right foot wound with betadine. On 9/9/21 at 4:00 p.m., the DON indicated there were many reasons why medications would have been late, nurses with poor time management, talking to residents, and situations the nurse needed to attend to. 3. On 9/5/21 at 7:08 p.m., QMA 10 indicated she was administering medications for all the residents upstairs in the Lofts 1 and Lofts 2. A review of the MAR indicated 17 residents were late for medication administration. The identifiers for these residents were AH, CQ, DG, DJ, DH, DK, DL, DM, DN, DP, DS, DT, [NAME], DV, DW, DX, [NAME], DZ, EB, EC, EF, EG, EJ, [NAME], EM, EN, and CL. On 9/5/21 at 7:15 p.m., QMA 10 indicated she had provided all the medications for all the residents since she arrived on her shift at 3:00 p.m. She had not signed off on the medications yet. She was aware she needed to provide the medications an hour before or an hour after the physicians' order. She had completed providing the medications on time according to the physicians' order but the only way she able to accomplish this task was not to sign off on the medications until the end of the shift. The facility was short staffed. This weekend was especially short staffed. It was not right to sign off on the medication administration late or from memory, but she indicated that it was the only way to get the medications to the residents on-time. She felt confident she could accurately sign-off on the residents' medication from memory. Usually, the facility provided a nurse and a QMA in each area but, the facility did not use agency and they didn't have enough staff. Her main concern was providing the medications on-time but knew she should have been charting as she provided the medications. On 9/9/21 at 4:00 p.m., the DON indicated she told the nurses to sign-off on medication as they do medication administration. A current policy, titled, Medication Administration, dated 5/29/19, was provided by the Regional Director of Clinical Operations (RDCO), on 9/8/21 at 3:22 p.m. A review of the policy, indicated, .Medications will be charted when given .Medications will be administered within the time frame of one hour before up to one hour after time ordered .Documentation of medication will be current for medication administration 4a. On 9/8/21 at 11:45 a.m., Registered Nurse (RN) 18 provided Resident BC's narcotic count sheet. The physician ordered Oxycodone (severe pain relief) 10 (milliliters) to be given by mouth every 4 hours. It was ordered on 8/31/21 and arrived at the facility on 8/31/21. The quantity dispensed by the pharmacy was 180 mL (milliliters). She indicated the doses given were as follows: a. On 9/1/21 at 12:00 midnight, the resident received the 1st dose of 10 mL. This dose reduced the quantity remaining to 170 ml. b. On 9/1/21 at 4:00 am, the resident received the 2nd dose of 10 mL. This dose reduced the quantity remaining to 160 ml. c. On 9/1/21 at 9:00 a.m., the resident received the 3rd dose of 10 mL. This dose reduced the quantity remaining to 150 ml. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 9/1/21 at 1:00 p.m., the resident received the 4th dose of 10 mL. This dose reduced the quantity remaining to 140 ml. e. On 9/2/21 at midnight, the resident refused a 10 mL dose of pain medication. f. On 9/2/21 at 4:00 a.m., the resident refused a 10 mL dose of pain medication. g. On 9/2/21 at 9:00 a.m., the resident received the 5th dose of 10 mL. This dose reduced the quantity remaining to 130 ml. h. On 9/3/21 at midnight, the resident received the 6th dose of 10 mL. This dose reduced the quantity remaining to 120 ml. i. On 9/3/21 at 4:00 a.m., the resident received the 7th dose of 10 mL. This dose reduced the quantity remaining to 110 ml. j. On 9/3/21 at 4:00 p.m., the resident received the 8th dose of 10 mL. This dose reduced the quantity remaining to 100 ml. k. On 9/3/21 at 8:00 p.m., the resident received the 9th dose of 10 mL. This dose reduced the quantity remaining to 90 ml. l. On 9/4/21 at midnight, the resident received the 10th dose of 10 mL. This dose reduced the quantity remaining to 80 ml. m. On 9/4/21 at 4:00 a.m., the resident received the 11th dose of 10 mL. This dose reduced the quantity remaining to 70 ml. n. On 9/4/21 at 12:00 noon, the resident received the 12th dose of 10 mL. This dose reduced the quantity remaining to 60 ml. o. On 9/4/21 at 4:00 p.m., the resident received the 13th dose of 10 mL. This dose reduced the quantity remaining to 50 ml. p. On 9/4/21 at 8:00 p.m., the resident received the 14th dose of 10 mL. This dose reduced the quantity remaining to 40 ml. q. On 9/5/21 at midnight, the resident received the 15th dose of 10 mL. This dose reduced the quantity remaining to 30 ml. r. On 9/5/21 at 4:00 a.m., the resident received the 16th dose of 10 mL. This dose reduced the quantity remaining to 20 ml. s. On 9/5/21 at 9:00 a.m., the resident received the 17th dose of 10 mL. This dose reduced the quantity remaining to 60 ml. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	t. On 9/5/21 at 1:00 p.m., the resident received the 18th dose of 10 mL. This dose should have reduced the quantity remaining to 0 ml. RN 18 indicated the 18th dose should have been the last dose in the bottle. Licensed Practical Nurse (LPN) 8 charted on the narcotic sheet, the bottle was over in mL. She added 30 mL to the narcotic sheet as pharmaceutical overage error. u. On 9/6/21 at midnight, the resident received the 19th dose of 10 mL. This means the total in the medication bottle, according to the facility charting was 190 ml. This dose reduced the quantity remaining to 20 mLs. v. On 9/6/21 at 4:00 a.m., the resident received the 20th dose of 10 mL. This means the total in the medication bottle, according to the facility's charting was 200 ml. This dose reduced the quantity remaining to 10 mLs. w. On 9/6/21 at 8:00 a.m., the resident received the 21st dose of 10 mL. This means the total in the medication bottle, according to the facility's charting was 210 mL. This dose did not reduce the quantity remaining. The charting indicated 10 mL were given and 10 mL remained in the bottle. x. On 9/6/21 at 1:00 p.m., the resident received the 22nd dose, a partial dose of 7.5 mL. This means the total in the medication bottle, according to the facility's charting was 217.5 mL. This dose reduced the quantity remaining to 0 mL. On 9/8/21 at 12:09 p.m., LPN 8 indicated Resident BC's oxycodone had over 180 mL in the bottle when it arrived from pharmacy. It was probably 200 mL or more when the bottle arrived here. All the narcotic pharmacy bottles arrived overfilled. It could have been over filled by 40 mL. Whatever was wrong with this narcotic started with the pharmacy. The nurses cannot calculate it properly, so they just use the amount that the pharmacy indicated was dispensed, but it was not an accurate amount in the bottle. During an interview, on 9/8/21 at 2:56 p.m., a representative pharmacist for the facility indicated the pharmacy would not have provided overage amounts of narcotic medications. The narcotic bottle may have had 1 or 2 mL of overage only. The pharmacy would not have over filled a narcotic bottle by nearly 40 mL. Every narcotic bottle had graduated measuring indicator on the side of the bottle to determine how full it was. On 9/9/21 at 4:25 p.m., Resident BC's Medication Administration Record (MAR) was reviewed and compared to the charting on the narcotic sheet for accuracy. a. On 9/2/21 at midnight, LPN 19, charted on the narcotic sheet that Resident BC refused his oxycodone 10 mLs of pain medication. On the MAR, on the same date and time, she indicated Resident BC took his oxycodone medication 10 mLs. b. On 9/2/21 at 4:00 a.m., LPN 19, charted on the narcotic sheet that Resident BC refused his oxycodone 10 mLs. On the MAR, on the same date and time, she indicated Resident BC took his oxycodone medication 10 mLs. c. On 9/3/21 at 4:00 p.m., LPN 20 charted on the narcotic sheet that Resident BC took his oxycodone 10 mLs. On the MAR, on the same date and time, she indicated Resident BC refused his oxycodone medication 10 mLs. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. On 9/4/21 at 8:00 p.m., Temp Med Tech (TMT) 21 charted on the narcotic sheet that Resident BC took his oxycodone 10 mLs. On the MAR, on the same date and time, she indicated Resident BC refused his oxycodone 10 mLs. 4b. On 9/8/21 at 3:58 p.m., Resident CX's hydrocodone apap (for severe pain relief) 7.5-325 mg (milligram) bottle was observed with LPN 22 for the quantity inside. It was 53 mL. The order indicated give 15 mL by mouth every 6 hours as needed (PRN) for pain. The narcotic sheet was observed to be inaccurate indicating 38 mL in the bottle. On 9/9/21 at 4:20 p.m., the Director of Nursing (DON) provided updated copy of Resident CX's narcotic sheet. After the quantity was identified as 38 mL on 9/8/21 at 3:58 p.m., the distribution of the remaining medication was as follows: a. On 9/8/21 at 1636 (4:36 p.m.), 15 mL were provided for the resident, with 23 mL remaining in the bottle. b. On 9/8/21 at 2145 (9:46 p.m.), 15 mL were provided for the resident with 8 mL remaining. These doses were not 6 hours apart. c. On 9/9/21 at midnight, an illegible name indicated the correct count remaining in the bottle was 20 mL. d. On 9/9/21 at 0630 (6:30 a.m.), 15 mL were given, leaving 5 mL in the bottle. e. On 9/9/21 at 7:00 a.m., an illegible name indicated the count was correct again with 10 mLs still in the bottle. f. On 9/9/21 at 11:21 a.m., 10 mL were given, leaving 0 mL in the bottle. On 9/10/21 at 11:41 a.m., Resident CX's MAR was reviewed and compared to the charting on the narcotic sheet for accuracy. a. On 9/1/21 at 6:00 a.m., LPN 23 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. b. On 9/2/21 at 12:30 a.m., LPN charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. c. On 9/2/21 at 12:00 p.m., the Assistant Director of Nursing (ADON) charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. d. On 9/5/21 at 8:00 p.m., LPN 7 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. e. On 9/7/21 at 2:40 a.m., LPN 23 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. (continued on next page)

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	155826	A. Building B. Wing	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f. On 9/7/21 at 11:00 p.m., LPN 10 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. g. On 9/8/21 at 6:30 a.m., LPN 23 charted on the narcotic sheet that Resident CX took his PRN oxycodone 15 mL. This dose was not charted on the MAR. On 9/10/211 at 3:30 p.m., the Director of Nursing (DON) provided statements signed by staff to account for additional liquid narcotics in the bottles: a. On 9/2/21 and 12 midnight and 4:00 a.m. LPN 19 indicated Resident BC had refused his liquid narcotic medication. She poured it back into the pharmacy bottle with a QMA as a witness. She was unaware that a QMA could not be witness to narcotic disposition. b. QMA 36 indicated she watched LPN 19 pour liquid medication back into the bottle but did not sign, as it was outside her scope of practice. c. On 9/4/21 at 8:00 p.m., QMA 9 indicated she poured Resident BC's liquid narcotic dose but then he refused, she poured to back into the bottle because she didn't know where to destroy it. d. On 9/4/21 at 8:00 p.m., LPN 8 indicated she watched QMA 36 pour Resident BC's liquid narcotic back into the bottle. On 9/8/21 at 3:58 p.m., the DON indicated the inaccuracy in liquid narcotic medications was a pouring error. On 9/10/21 at 3:34 p.m., the DON indicated the nurses were pouring the liquid narcotic medications back into the pharmacy bottle if the resident refused to take it. For Resident BC, a nurse and a QMA witnessed the dose being poured back in the pharmacy bottle. On 9/10/21 at 3:55 p.m., the VPCO indicated the MAR should have reflected the medication administration or disposition of the medication. On 9/9/21 at 4:30 p.m., the AIT indicated the narcotic charting should have been accurate and all narcotic medication should have been accounted for in the charting. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current policy, titled, Medication Controlled Drugs and Security, dated 7/25/18, was provided by the RDCO, on 9/8/21 at 3:22 p.m. A review of the policy, indicated, .Narcotics will be counted at change of shift and upon being relieved from duty, the qualified staff accepting responsibility for the count .Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with the nurse reporting off duty .The inventory of the controlled drugs, count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count .the controlled drug record must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct after the count has been completed .In the event a discrepancy is found, check the resident's medication sheets and chart to see if a narcotic has been administered and not recorded .check previous recordings on the control sheets for mistakes in arithmetic .If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the supervisor for immediate investigation .Nurses, or qualified medication aide may not leave the unit until directed to do so by the immediate supervisor .The incident will be investigated and reported to the Administration leadership .Any suspicion of substitution or tampering with controlled drugs must be reported to the DON immediately .DON will notify consultant pharmacist and administrator immediately for further action A current policy, titled, Controlled Substance Disposal, with no date, was provided by the VPCO, on 9/10/21 at 5:03 p.m. A review of the policy indicated, .When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nursing personnel, and the disposal is documented on the accountability record on the line representing that dose This Federal tag relates to Complaint IN00361468. 3.1-14(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37981 Based on observation, interview, and record review, the facility failed to ensure a treatment cart was locked with prescription medication inside for 1 of 2 random observations for treatment carts (Resident DB, DA, BL, DC, DD, DE, and DF), failed to ensure all prescription medications were secured for 1 of 2 random observations for secured medications (Resident CY and CZ), and failed to ensure correct physician orders were on a prescription bottle for 1 of 8 prescription bottled reviewed for correct labels (Resident CX). Findings include: 1. On 9/5/21 at 10:00 p.m., a treatment cart on Heritage 2 was observed unlocked. Twenty-three tubes of prescription medications were observed in the first drawer. Resident DA's 3 tubes of medication were in a plastic bag and 8 other tubes of prescription medication were in the second drawer. On 9/8/21 at 9:50 a.m., the Administration in Training (AIT) provided the following resident prescription medications in the unlocked treatment cart: a. Resident DB had one tube of aspercreme 4% lidocaine (pain relief). b. Resident DA had 6 tubes of diclofenac sodium gel 1%, lidocaine 5% cream (pain relief), and 15 discontinued tubes of nystatin-triamcinolone ointment 100,000-01% (antifungal). c. Resident BL had 2 bottles of Dakin's 1/4 strength solution 0.125% (wound antiseptic). d. Resident DC had 1 tube of proctosol cream 2.5% (reduces redness, swelling, itching). e. Resident DD had 3 tubes of bio-freeze gel 4% (pain relief). f. Resident DE had 4 bottles of ammonium lactate cream 12% (skin hydration). g. Resident DF had 6 tubes of bio-freeze gel 4%. On 9/8/21 at 10:02 a.m., the AIT indicated all the treatment carts should be locked. On 9/8/21 at 11:14 a.m., the Minimum Data Set Coordinator (MDSC) provided mental status scores of residents on the Heritage hallway. A review of these documents indicated 11 of 34 residents were moderately or severely cognitively impaired. 2. On 9/5/21 at 8:06 p.m., two prescription medications were randomly observed unsecured in a nurse's station cabinet. a. Resident CY's atorvastatin 40 mg, DC (discontinue) was written on the label. It was a blister pack with pills still in it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident CZ's pyridostigmine 60 mg tablets. Instructions indicated to give 1 tablet by mouth 3 times a day for constipation. On 9/8/21 at 10:01 a.m., the AIT indicated no medications should have been unlocked and available for anyone to grab. On 9/8/21 at 11:14 a.m., the MDS Coordinator provided mental status scores of residents on the Lofts 2 hallway. A review of these documents indicated 8 of 19 residents were moderately or severely cognitively impaired. 3. On 9/8/21 at 3:58 p.m., an observation of Resident CX's hydrocodone-acetaminophen 7.5-325 mg label instructions indicated give every 6 hours as needed for pain. Licensed Practical Nurse (LPN) 22 indicated the physician had changed the orders to give every 4 hours for pain. She did not know when the order had changed. On 9/9/21 at 1:22 p.m., Resident CX's Medication Administration Record (MAR) was reviewed. His physician's order for hydrocodone-acetaminophen solution 7.5-325 mg indication to give by mouth every 4 hours as needed for pain. The new order started on 9/5/21. On 9/9/21 at 3:43 p.m., the AIT indicated the facility had direction change, stickers to put on medication labels when physician orders changed. A new label should have been requested. A current policy, titled, Administration Procedures for All Medications, with no date, was provided by the [NAME] President of Clinical Operations, on 9/10/21 at 5:03 p.m. A review of the policy indicated, .All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aids .Prior to removing medication package/container. Prior to removing medication package/container from the cart/drawer: Check MAR/TAR (treatment administration record) for order This Federal tag relates to Complaint IN00361468. 3.1-25(k)(5) 3.1-25(m)