DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 08/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SWEET GALILEE AT THE WIGWAM | 1315 JOHN STREET<br>ANDERSON, IN 46016 |

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| R 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00439676, IN00440693, and IN00441033.<br><br>Complaint IN00439676 - State deficiencies related to the allegations are cited at R0090.<br><br>Complaint IN00440693 - State deficiencies related to the allegations are cited at R0053 and R0090.<br><br>Complaint IN00441033- State deficiencies related to the allegations are cited at R0304.<br><br>Unrelated deficiency is cited.<br><br>Survey dates: 8/14/24- 8/15/24<br><br>Facility number: 014706<br><br>Residential Census: 80<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed August 20, 2024. | R 0000 | | |
| R 0053<br><br>Bldg. 00 | 410 IAC 16.2-5-1.2(w)<br>Residents' Rights - Deficiency<br>(w) Residents have the right to be free from verbal abuse.<br>Based on record review and interview, the facility failed to ensure residents remained free from verbal abuse for 1 of 3 residents review for verbal abuse. (Resident D)<br><br>Findings include:<br><br>Review of an 8/9/24, facility self-reported incident | R 0053 | The deficiency has the potential to affect all Residents. Resident D no longer feels uncomfortable in the dining room.<br><br>The Executive Director has been inserviced on the policy and procedure for Abuse and Neglect | 09/06/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Erin Tuttle | Regional Director of Operations | 09/03/2024 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | indicated the following: "Brief Description of Incident": Staff reported that while serving the resident in the dining room, the resident asked that her cover off her plate taken, the staff said one moment, and the resident became angry, demanding the staff do it now. The staff began yelling at the resident, and the resident yelled back.<br><br>Resident D's clinical record was reviewed on 8/14/24 at 11:48 a.m. Current diagnosis included attention-deficit/hyperactivity disorder (ADHD), emphysema, binge eating disorder, and anxiety.<br><br>A current "Level of Service Plan", dated 7/5/24, indicated Resident D was alert and oriented and ate independently.<br><br>Current physician's orders included: Xanax (to treat anxiety) 0.25 milligrams (mg) tab, take 1 by mouth three times daily as needed for anxiety.<br><br>A review of the facility investigation file, provided by the Administrator, on 8/14/24 at 1:54 p.m. indicated the following:<br><br>A 8/9/24, hand written statement from the Administrator indicated she was called to the dining room due to staff yelling at a resident. She asked the staff member to go to her office and asked Resident D if they were okay. When the resident indicated they were okay, the Administrator apologized for the incident and went to her office. The employee, HHA 3 was very upset. HHA 3 continued to yell that she was tired of Resident D's attitude. The Administrator indicated this behavior was abusive and when the staff member indicated she did not care, the Administrator took this as the employees resignation. The Administrator told HHA 3 she | | which includes interviewing individuals that are in proximity of an incident.<br><br>The facility has inserviced the staff on Abuse and Neglect.<br><br>The Regional Director of Operations/Designee will review any abuse investigations to ensure compliance with the regulation weekly for the next 4 weeks then monthly for the next 3 months. The findings will be reported to the QAPI committee for the next 6 months.<br><br>Negative variances will be corrected at the time of finding and will be reported to the community's QAPI committee.<br><br>The Executive Director is responsible for maintaining the compliance of this regulation. | |

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was terminated from her position due to her behavior.

A 8/13/24, "Note", by the Administrator indicated she follow-up with Resident D. Resident D indicated they felt better and were glad that HHA 3 is no longer here. The resident indicated there was nothing else they needed done.

The investigation file lacked additional resident or staff interviews.

A review of HHA 3's employee file, on 8/15/24 at 2:24 p.m., indicated her hire date was 12/14/23.

A, 12/14/23, "Resident Rights" document, acknowledged and signed by HHA 3.

A, 12/14/23, "Abuse and Neglect Policy" document, acknowledged and signed by HHA 3.

During an interview, on 8/14/24 at 2:22 p.m., Resident D indicated they had been seated in the dining room and asked the staff member if she was going to take the lid from the dish placed in front of them. The staff member, HHA 3, then started yelling that is wasn't a five star hotel. Resident D did yell back at her. She said that another staff member and a few other residents attempted to stop the argument, but it wasn't until the Administrator came out that HHA 3 left the dining room. Resident D indicated they immediately went upstairs to take some Xanax to help calm down. Resident D indicated they needed to take the Xanax every day since the incident to help feel comfortable going to the dining room for meals.

During an interview, on 8/15/24 at 3:15 p.m., the Administrator indicated she was working in her office on the day Resident D was yelled at by a

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| | staff member. She heard the yelling and assuming it was amongst the residents and went out to see how she could defuse the situation. In the dining room, she saw HHA 3 and Resident D yelling at each other. She asked the staff member to go to her office and spent some time apologizing to Resident D. Then she went to her office and spoke with the employee. HHA 3 was very upset and unwilling to calm down. The conversation ended with HHA 3 being terminated for her behavior. HHA 3 left the facility without issue. The Administrator indicated she had spoken to Resident D afterwards and they stated they were fine.<br><br>A current facility policy, effective 1/22, titled " Resident's Personal Rights Policy and Procedure", provided by the Administrator, on 8/14/24 at 9:50 a.m., indicated the following: "... Each resident shall have the right to: 1. Be free from mental, emotional, social, and physical abuse and neglect..."<br><br>This citation relates to Complaint IN00440693. | | | |
| R 0090<br><br>Bldg. 00 | 410 IAC 16.2-5-1.3(g)(1-6)<br>Administration and Management - Deficiency<br>(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:<br>(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual | | | |

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| | occurrences include, but are not limited to:<br>(A) epidemic outbreaks;<br>(B)poisonings;<br>(C) fires; or<br>(D) major accidents.<br>If the division cannot be reached, a call shall be made to the emergency telephone number published by the division.<br>(2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative.<br>(3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility.<br>(4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:<br>(A) employee's full name; and<br>(B) dates and hours worked during the past twelve (12) months.<br>(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.<br>(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request | | | |
| | Based on interview and record review, the facility failed to complete thorough investigations of alleged abuse for 2 of 3 residents reviewed for abuse. (Residents B and D) | R 0090 | The deficiency has the potential to affect all Residents. Resident B no longer resides at the community. | 09/06/2024 |

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| | Findings include:<br><br>1. A 7/26/24, facility self-reported incident indicated the following: "Brief Description of Incident": Resident B was in the dining room yelling at Resident C, staff intervened and Resident B left. A short time later, the Resident B returned to the dining room and Resident C tased Resident B. Resident B left the community. 911 was called. An officer arrived, instructed staff to retrieve the taser, and secure it. Staff immediately secured the taser and residents were instructed to stay clear of each other. Resident B was placed on 15 minute checks for 72 hours. Resident C was instructed to avoid contact with Resident B.<br><br>Resident B's clinical record was reviewed on 8/14/24 at 10:15 a.m. Current diagnosis included hypertension, rash, and itching.<br><br>A current "Assisted Living Facilities/Adult Care Home Assessment and Care Screening" document, dated 3/28/24, indicated Resident B was verbally abusive and socially inappropriate and disruptive.<br><br>A current "Level of Service Assessment", dated 5/28/24, indicated no behaviors were noted.<br><br>A "nursing task", dated 7/26/24, indicated to check the resident every 15 minutes for 72 hours.<br><br>A "note", dated 7/26/24 at 9:45 p.m., indicated Resident B was in the dining room again, intoxicated and being rude to residents. Resident B left the building before staff could speak with him.<br><br>A review of the facility investigation file, provided by the Administrator, on 8/14/24 at 11:34 a.m., | | The Executive Director has been inserviced on the policy and procedure for Abuse and Neglect which includes interviewing more individuals that are in proximity of an incident, ensuring any outside agency reports are included, and the necessity that any items involved in an incident are kept in a secure location.<br><br>The DON and Nursing staff were inserviced on the specifics of documenting for time checks on Residents to ensure that all necessary documentation is completed timely and for the correct duration.<br><br>The facility has inserviced the staff on Abuse and Neglect.<br><br>The Regional Director of Operations/Designee will review any abuse investigations to ensure compliance with the regulation weekly for the next 4 weeks then monthly for the next 3 months. The findings will be reported to the QAPI committee for the next 6 months.<br><br>Negative variances will be corrected at the time of finding and will be reported to the community's QAPI committee.<br><br>The Executive Director is responsible for maintaining the compliance of this regulation. | |

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| | indicated the following:<br><br>A "nursing task", dated 7/26/24, for Resident B indicated to check resident every 15 minutes for 72 hours.<br><br>A 7/31/24, "All Staff Meeting Sign- In Sheet" was documented to cover the following subjects: scheduling, bed bugs, entering a resident room, pay changes, abuse, and neglect. The sign in sheet contained 21 employee signatures.<br><br>The facility investigation file lacked resident interviews, staff interviews, or documentation of completed 15 minute checks.<br><br>The facility investigation file lacked the location of the taser.<br><br>The facility investigation file lacked the police report.<br><br>During an interview, on 8/15/24 at 1:52 p.m., the DON indicated the nursing task for Resident B's 15 minute checks was entered incorrectly and did not repeat. The checks were not completed.<br><br>During an interview, on 8/15/24 at 3:15 p.m., the Administrator indicated there was no additional information to provide related to this incident. She was not able to locate the taser.<br><br>2. A 8/9/24, facility self-reported incident indicated the following: "Brief Description of Incident": Staff reported that while serving the resident in the dining room, the resident asked that her cover off her plate taken, the staff said one moment, and the resident became angry, demanding the staff do it now. The staff began yelling at the resident, and the resident yelled back. | | | |

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Resident D's clinical record was reviewed on 8/14/24 at 11:48 a.m. Current diagnosis included attention-deficit/hyperactivity disorder (ADHD), emphysema, binge eating disorder, and anxiety.

A current "Level of Service Plan", dated 7/5/24, indicated Resident D was alert and oriented, self administers medications, and eats independently.

Current physician's orders included: Xanax (to treat anxiety) 0.25 milligrams (mg) tab, take 1 by mouth three times daily as needed for anxiety.

A review of the facility investigation file, provided by the Administrator, on 8/14/24 at 1:54 p.m. indicated the following:

A 8/9/24, hand written statement from the Administrator indicated she was called to the dining room due to staff yelling at a resident. She asked the staff member to go to her office and asked Resident D if they were okay. When the resident indicated they were okay, the Administrator apologized for the incident and went to her office. The employee, HHA 3 was very upset. HHA 3 continued to yell that she was tired of Resident D's attitude. The Administrator indicated this behavior is abusive and when the staff member indicated she did not care, the Administrator took this as the employees resignation. The Administrator told HHA 3 she was terminated from her position due to her behavior.

A 8/13/24, "Note", by the Administrator indicated she follow-up with Resident D. Resident D indicated they felt better and was glad that HHA 3 was no longer there. The resident indicated there was nothing else they needed done.

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| | The investigation file lacked additional resident or staff interviews regarding abuse.<br><br>During an interview, on 8/15/24 at 3:15 p.m., the Administrator indicated she had no additional information to provide.<br><br>A current facility policy, effective 1/22, titled, "Abuse, Neglect, and Financial Exploitation Prevention", provided by the Administrator, on 8/14/24 at 10:00 a.m., indicated the following: "... The Department Manager along with the Administrator will investigate the reported incident within 24 hours of the report. Interviews with staff, witnesses, and residents will be initiated and conducted by the Department Manager and the Administrator. Documentation of the investigation will be maintained by the Administrator..."<br><br>This citation relates to Complaints IN00440693 and IN00439676. | | | |
| R 0217<br><br>Bldg. 00 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br>(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:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and<br>(D) preference;<br>of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed by the | | | |

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| | resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br>(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.<br>(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.<br>(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 record review and interview, the facility failed to ensure service plans were signed by residents or resident representatives for 3 of 3 residents reviewed for service plans. (Residents B, C, and D)<br><br>Findings include:<br><br>1. Resident B's clinical record was reviewed on 8/14/24 at 10:15 a.m. Diagnosis included hypertension, rash, and itching.<br><br>A current service plan, dated 4/18/24, indicated the resident was alert and oriented, independent with ambulation, and was a smoker. The service plan lacked a resident or resident representative signature.<br><br>2. Resident C's clinical record was reviewed on 8/14/24 at 10:51 a.m. Diagnosis included hypertension, diabetes mellitus type 2, and neuropathy.<br><br>An undated service plan, indicated the resident | R 0217 | Resident C and Resident D's Service Plans have been reviewed with the Residents and Signatures are confirmed.<br><br>The community will audit all Resident Service Plans and ensure each Resident/Representative has signed the Service Plan.<br><br>The DON and Nurses will be inserviced on this regulation to ensure compliance and understanding of the regulation.<br><br>Resident Service Plans will be reviewed monthly for signatures by the DON/Designee for the next 3 months and random audits will continue for 3 months thereafter. Negative variances will be corrected at the time of finding and will be reported to the | 09/06/2024 |

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| | was alert, independent with mobility, and was a fall risk. The service plan lacked a resident or resident representative signature.<br><br>3. Resident D's clinical record was reviewed on 8/14/24 at 11:48 a.m. Diagnosis included emphysema, attention-deficit/hyperactivity disorder (ADHD), and anxiety.<br><br>A current service plan, dated 7/24/24, indicated the resident utilized a power wheel chair for mobility, required oxygen on a daily basis, and was a fall risk. The service plan lacked a resident or resident representative signature.<br><br>During an interview, on 8/15/24 at 1:52 p.m., the DON indicated the expectation for updating service plans was for the resident or resident representative to sign this document.<br><br>A current facility policy, last revised on 6/22, titled, "Service Plans", provided by the Administrator, on 8/15/24 at 4:00 p.m., indicated the following: "...4. The agreed upon service plan shall be signed and dated by the resident..." | | community's QAPI committee.<br><br>The Executive Director is responsible for the continued compliance of the regulation. | |
| R 0304<br><br>Bldg. 00 | 410 IAC 16.2-5-6(e)<br>Pharmaceutical Services - Deficiency<br>(e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. | | | |
| | Based on record review and interview, the facility failed to ensure secure storage and reconciliation of resident medications handled by the facility for 3 of 3 residents reviewed for medication storage. | R 0304 | No Residents had adverse reaction to the missing medications. | 09/06/2024 |

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| | This deficient practice resulted in a total of 54 missing pills for the 3 residents who were reviewed for missing medication (Resident C, E, and F).<br><br>Findings include:<br><br>A 8/14/24, facility self-reported incident indicated the following: "Brief Description of Incident": while conducting a medication count the staff noticed that there were some discrepancies with the medication counts for 3 residents: Resident E had 90 tablets of oxycodone (a narcotic) delivered in a red sealed bag, however during the count there were only 60 tablets present. Resident F was missing 2 tablets of tramadol (a narcotic), 6 tablets of Lyrica (to treat nerve pain), and 8 tablets of oxycodone. Resident C had been out of the community since 8/6/24 and was missing 4 tablets of hydrocodone (a narcotic) and 4 tablets of gabapentin (to treat nerve pain).<br><br>Resident C's clinical record was reviewed on 8/14/24 at 10:51 a.m. Current diagnosis included hypertension, diabetes mellitus type 2, and neuropathy.<br><br>Current physician's orders indicated hydrocodone 7.5-325 milligrams (mg) take 1 tablet four times a day at 6:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. and gabapentin 400 mg take 1 tablet three times a day at 6:00 a.m., 4:00 p.m., and 8:00 p.m.<br><br>Resident E's clinical record was reviewed on 8/15/24 at 11:25 a.m. Current diagnosis included hyperthyroidism, hypertension, and diabetes mellitus type 2.<br><br>A current physician's order indicated oxycodone 5 mg take 1 tablet by mouth every 4 hours. | | The community audited each Resident's medications and found no other missing medications.<br><br>The DON Designee inserviced all medication administration personnel on Narcotic Count and notification for missing medications.<br><br>The DON/Designee will audit the narcotic count book weekly times 4 weeks and monthly for 4 months. Negative variances will be corrected at the time of identification and reported to the QAPI committee for 6 months.<br><br>The DON/Designee will audit the Resident routine narcotics weekly times 4 weeks and monthly for 4 months. Negative variances will be corrected at the time of identification and reported the QAPI committee for 6 months.<br><br>The Executive Director is responsible for continued compliance of the regulation. | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| SWEET GALILEE AT THE WIGWAM | 1315 JOHN STREET<br>ANDERSON, IN 46016 |

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Resident F's clinical record was reviewed on 8/15/24 at 11:35 a.m. Current diagnosis included Chronic Obstructive Pulmonary Disease (COPD) and chronic pain syndrome.

Current physician's orders indicated oxycodone 10-325 mg take 1 tablet by mouth at 8:00 a.m., 12:00 p.m., and 4:00 p.m., Lyrica 100 mg take 1 tablet by mouth three times a day, and tramadol 50 mg take 1 tablet by mouth at 10:00 a.m., 2:00 p.m., 6:00 p.m., and 9:00 p.m.

A review of the facility investigation file, provided by the Administrator, on 8/15/24 at 11:40 a.m., indicated the following:

A "24- hour Daily Shift Report", completed by RN 4, on 8/14/24, to audit the current number of medication pills for each of the resident the facility assisted with medication administration, indicated the following: Resident C was missing 4 tablets of hydrocodone 7.5-325 mg and 4 tablets of gabapentin 400 mg. Resident E was missing 30 tablets of oxycodone 5 mg. Resident F was missing 8 tablets of oxycodone 10-325 mg, 6 tablets of Lyrica 100 mg, and 2 tablets of tramadol 50 mg.

A 8/14/24, hand written statement by QMA 5, indicated she was aware of a pharmacy delivery on 8/13/24 that contained a sealed bag of narcotics. The sealed bag was put into the narcotics box and was handed off to the staff on second shift. When she went to grab medication for Resident E, she saw the bag was no longer sealed, but the count sheets included were not filled in. She took the count sheets to the desk and began to fill them out, when she noticed something was wrong. The pharmacy sheet

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| | indicated there were 90 tablets of the oxycodone 5 mg, but she only counted 60 tablets in the narcotic box. She immediately notified the charge nurse. She assisted RN 4 on the room-to-room audit for the resident's the facility administers medications for.<br><br>A 8/14/24, hand written statement by LPN 6, indicated she presented the second shift with the sealed bag containing narcotics since the residents were not available during her shift. She did not accept the delivery from the pharmacy.<br><br>A 8/14/24, hand written statement by RN 4, indicated he received a sealed bag of medication from the narcotics box from the staff member leaving the day shift. The sealed bag was placed back into the narcotics box. He handed the sealed bag to the night shift nurse at the end of his shift.<br><br>A 8/15/24, hand written statement by QMA 7, indicated she accepted the pharmacy delivery on the morning of 8/13/24. The sealed bag contained narcotic medications for two residents. She placed the sealed bag into the narcotic lock box. She handed off the medication keys to the first shift staff on 8/13/24. When she returned to work on the night of 8/13/24, the bag was still sealed and the previous employee told her they had not had time to deliver these medications. At that point, QMA 7 indicated she opened the bag and counted the 90 tablets of Oxycodone 5 mg for Resident E. She locked them in the narcotic box and worked her shift. She handed the keys off and did her morning report as usual and then left. She found out about the missing medications once she woke up in the afternoon on 8/14/24.<br><br>A "pharmacy medication count" sheet, dated 8/13/24, indicated QMA 7 signed for the | | | |

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medication delivery.

During an interview, on 8/15/24 at 9:50 a.m., LPN 6 indicated when the pharmacy made a delivery there was usually a red see-through bag containing narcotics taped to the top of the box. An employee is supposed to sign and accept the delivery. Once the red bag is torn open, the employee must sign the narcotic count sheet and fax that to the pharmacy. She knew she would not have time to deliver the narcotics on 8/13/24 and just left them locked up. She thought the night shift before her had to have signed for them.

During an interview, on 8/15/24 at 10:37 a.m., RN 4 indicated pharmacy deliveries happened early in the morning, usually on night shift. The staff was supposed to do the medication reconciliation at that time, but it did not always happen. When he came on shift on 8/13/24, LPN 6 handed off the medication keys and the sealed red bag of narcotics. He placed it in the narcotic box and left it alone, he passed the bag onto the midnight shift employee, QMA 7. When he came to work on 8/14/24, he was made aware of the missing medications and did a room-to-room audit of the residents medications that the facility administered.

During an interview, on 8/15/24 at 10:57 a.m., QMA 7 indicated when the pharmacy delivered medications, one person signed to accepted the package. If they didn't open the sealed red bag, they wouldn't be able to sign the count sheet. She accepted the pharmacy delivery on the morning of 8/13/24, and placed the sealed bag into the locked narcotics box. She passed the bag off the morning shift staff. When she came back to work on the night of 8/13/24 the bag was still sealed shut. During her shift, she opened the sealed bag,

counted the narcotic medications, and locked them in the narcotic box. She passed off the keys and did her morning report as normal on 8/14/24.

During an interview, on 8/15/24 at 10:57 a.m., the DON indicated the when the pharmacy delivered medication, the staff member that accepted the delivery should sign for the package and do a reconciliation immediately.

A 8/24 ,"Controlled Medication Count Verification" sheet, provided by the DON, on 8/15/24 at 11:00 a.m., contained no staff signatures from 8/1/24- 8/11/24. The 8/13/24 night shift sign off was signed by QMA 7 and the on-coming nurse was signed by QMA 5.

During a follow-up interview, on 8/15/24 at 11:22 a.m., the DON indicated the expectation was for all shifts to do a narcotic count and sign the "Controlled Medication Count Verification" when coming on shift and going off shift. She indicated she was not sure why this was not completed.

A current facility policy, effective 1/24, titled, "Medication Management, Administration, and Storage", provided by the Administrator, on 8/15/24 at 10:00 a.m., indicated the following: " ... 1. It is the responsibility of all authorized healthcare professionals to ensure that all medications are appropriately secured at all times except when authorized personnel are present .... 2. It is the responsibility of the Director of Nursing or licensed nurse, to receive, review, against current orders and reconcile medications upon delivery. 3. For residents receiving administration assistance, all medication deliveries from the contracted pharmacy will be received and reviewed by a licensed nurse or QMA. A license nurse or QMA will ensure that all medications are

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| | delivered to the residents apartments and placed in locked boxes, if applicable..."<br><br>This citation relates to Complaint IN00441033. | | | |