

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

PRINTED: 01/29/2024
FORM APPROVED
OMB NO. 0938-0391

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|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155655 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED C 01/19/2024 |
| NAME OF PROVIDER OR SUPPLIER PEABODY RETIREMENT COMMUNITY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 400 W SEVENTH ST NORTH MANCHESTER, IN 46962 | | |
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| F 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00419428, IN00420619, IN00420827, IN00423217, IN00423753, IN00424683, and IN00419835.</p> <p>Complaint IN00419428 - Federal/State deficiencies related to the allegations are cited at F602.</p> <p>Complaint IN00420619 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00420827 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00423217 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00423753 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00424683 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00419835 - No deficiencies related to the allegations are cited.</p> <p>Survey dates: January 17 and 19, 2024.</p> <p>Facility number: 000485 Provider number: 155655 AIM number: 100291190</p> <p>Census Bed Type: SNF/NF: 167 Total: 167</p> | F 000 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| F 000 | Continued From page 1 Census Payor Type: Medicare: 9 Medicaid: 95 Other: 63 Total: 167 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 26, 2024. | F 000 | | | |
| F 602 SS=D | Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident's narcotic medication was free from diversion for 1 of 1 resident reviewed for misappropriation of medication (Resident B). The deficient practice was corrected on 10/10/23, prior to the start of the survey, and was therefore past noncompliance. Findings include: Resident B's clinical record was reviewed on 1/17/24 at 10:00 a.m. Diagnoses included unspecified sequelae of cerebral infarction, difficulty in walking, weakness, other lack of coordination, need for assistance with personal | F 602 | Past noncompliance: no plan of correction required. | | |

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| F 602 | <p>Continued From page 2</p> <p>care, acquired absence of left leg below knee, carcinoma in situ of bladder, and chronic pain syndrome.</p> <p>His medications included oxycodone-acetaminophen (narcotic pain medication) 7.5-325 mg (milligram) three times daily and oxycodone-acetaminophen 7.5-325 mg every six hours as needed (PRN) for chronic pain.</p> <p>He had a care plan for receiving pain medication related to cancer (9/19/23).</p> <p>His October 2023 Medication Administration Record (MAR) indicated LPN 6 gave Resident B an oxycodone-acetaminophen 7.5-325 mg at 6:00 a.m. and 12:00 p.m. on 10/7/23. No PRN medication was documented as given on 10/7/23.</p> <p>His clinical record lacked a controlled drug receipt/record/disposition form verifying the count when the 6:00 a.m. dose given on 10/7/23.</p> <p>His clinical record lacked a controlled drug receipt/record/disposition form for oxycodone-acetaminophen 7.5-325 mg numbered "one of two" with a quantity of 15 out of 45 pills.</p> <p>His controlled drug receipt/record/disposition form for oxycodone-acetaminophen 7.5-325 mg numbered "two of two," with a quantity of 30 out of 45 pills, indicated LPN 6 signed off the first dose given from this medication card, on 10/7/23 at 12:00 p.m., with 29 pills remaining and again at 4:30 p.m., with 28 pills remaining. QMA 17 signed off one pill on 10/7/23 at 7:37 p.m. with 27 pills remaining.</p> | F 602 | | | |

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| F 602 | <p>Continued From page 3</p> <p>His "Controlled Medication Shift Change Log" indicated the following:</p> <p>a. On 10/6/23 at 6:00 p.m., QMA 17 (on-coming shift) verified there were 13 count sheets/narcotic medication cards.</p> <p>b. On 10/7/23 at 6:00 a.m., QMA 17 (off-going shift) and LPN 6 (on-coming shift) verified there was one less count sheet/narcotic medication card for a total of 12, due to one of the resident's card's being exhausted and the reasoning was noted on the back of the form.</p> <p>c. On 10/7/23 at 6:00 p.m., QMA 17 (on-coming shift) and LPN 6 (off-going shift) verified there was one less count sheet/narcotic medication card. The formed lacked the reasoning for one less count sheet/narcotic medication card.</p> <p>The facility investigation binder, provided by the DON was reviewed on 1/17/24 at 2:05 p.m. and included the following:</p> <ol style="list-style-type: none"> 1. A summary of the investigation. 2. A typed statement by RN 3 which indicated at approximately 10:30 p.m. on 10/7/23, she was notified by QMA 17 that she thought there was a missing narcotic medication record sheet. They searched the nurses station trash and shred box. They located an old medication record sheet for oxycodone-acetaminophen with documentation it was finished 10/5/23 for 30 tabs and a cut label of a partial order of oxycodone-acetaminophen delivered on 9/27/23 for 15 tabs. Both were discovered in the document shred box. They searched the medication carts, and all controlled | F 602 | | | |

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| F 602 | <p>Continued From page 4</p> <p>substances were accounted for. They reviewed the total count sheets and there was one less sheet/card, and the count was correct, but nothing was noted on the back of the form. There were no medications or other medication record sheets found. The on-call nurse was notified of the potential missing medication record.</p> <p>3. A handwritten statement by QMA 17, dated 10/7/23, indicated one of the residents asked for a PRN Norco (narcotic pain medication). When she pulled it from the medication cart, she noticed two doses were given around 6:00 a.m. and 10:00 a.m. that morning, which was not normal for that resident. She asked the resident if she had taken them that morning and she stated no. This prompted the QMA to check the rest of the narcotics. She checked the controlled medication shift change log and noticed a discrepancy with LPN 6's documentation, with whom she had counted with that morning, had one less count sheet/medication card on the form. She looked on the back of the form and the information was not written down. She then looked in the nurse's station and could not find the sheet or the empty card label. She then notified the nurse in on the other unit that she needed help to figure out the situation. They looked into it together and noticed there was definitely a card and a form missing.</p> <p>4. A facility corrective action plan indicated the following:</p> <p>a. A facility wide controlled substance and correlating reconciliation sheet audit was performed with no missing controlled substances or reconciliation sheets noted (10/9/23). Residents pain assessments were completed without unexpected or negative findings</p> | F 602 | | | |

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| F 602 | <p>Continued From page 5 (10/10/23). LPN 6's electronic controlled substance medication administration record validated for all shifts worked (10/10/23). Electronic medical records were reviewed for Health Center West to ensure that reconciliation sheets were properly uploaded (10/10/23).</p> <p>b. A meeting was conducted with the agency who employed LPN 6 regarding policies and procedures for contracted employees (10/10/23). Notification was given to the agency that LPN 6 was not to return to the facility (10/10/23). Education was provided to all licensed staff regarding controlled substances and abuse/neglect including agency licensed staff (10/10/23).</p> <p>c. A quality assurance tool was developed and implemented to monitor the compliance of controlled substances to ensure proper reconciliation. The audit would be completed by the DON, or designee, weekly for four weeks then monthly for five months. The results would be reported to the facilities quality assurance program for review. Any negative findings would add an additional month of auditing until 100% compliance was achieved.</p> <p>During an interview with the DON, on 1/17/24 at 2:50 p.m., she indicated a resident requested pain medication from QMA 17. QMA 17 checked, and the resident had taken two doses earlier in the day on 10/7/23, which was not normal for that resident. When QMA 17 asked that resident if she received pain medication earlier in the day the resident denied getting pain medication. QMA 17 investigated it more and noticed the count sheet indicated one less count sheet/medication card but with no explanation on the back of the form.</p> | F 602 | | | |

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| F 602 | <p>Continued From page 6</p> <p>QMA noticed Resident B's narcotic medication punch card was missing. She reported it to the nurse. They found the label from the top of the missing narcotic medication punch card, labeled one of two that contained 15 of 45 pills, in the shred box along with a previous completed controlled drug receipt/record/disposition form. The controlled drug receipt/record/disposition form for the 15 of 45 pills was missing. From 10/5/23 at 6:00 p.m. to 10/7/23 at 7:00 a.m., six doses were documented on the MAR and nine doses should had been left in the punch card that was missing. As they compared the count sheets, the MAR and the shift change log, LPN 6 was the last one to give a pill from the punch card that contained the 15 of 45 pills and she was the first to give a pill from the two of two card that contained 30 of 45 pills. She was unable to get ahold of LPN 6 during the investigation. It was concluded LPN 6 was in custody of the medication at the time the card went missing. Also, there had been previous facilities who had reported her for drug diversion.</p> <p>During an interview with QMA 17, on 1/19/24 at 4:41 p.m., she indicated she worked on 10/6/23 from 6:00 p.m. to 6:00 a.m. and LPN 6 came in after her on 10/7/23 from 6:00 a.m. to 6:00 p.m. QMA 17 came back to work on 10/7/23 at 6:00 p.m. When she looked at the signoff sheet for Resident B's pain medication, the times didn't add up and LPN 6's writing was sloppy. She had just worked the 12 hours prior and the number of pills that were gone did not add up. Resident B could not had taken that many pills in a 12-hour period. She called a nurse over and they started to investigate it. They normally did count with the oncoming and off going nurses, and they used the count sheets and cards to make sure they</p> | F 602 | | | |

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| F 602 | <p>Continued From page 7</p> <p>matched. A lot of the nurses were not writing in why a sheet/card was added, they skipped this step. She did not. LPN 6 seemed "flighty" that day and was in a rush to get out of there, but it was the first time she had met her, so she thought maybe she was just ready to get off work.</p> <p>A current facility policy, revised 4/2019, titled "Controlled Substances," provided by the Administrator on 1/22/23 at 9:41 a.m., indicated the following: "...12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. b. Any discrepancies in the controlled substance count are documented and reported to the Director of Nursing Services immediately. c. The Director of Nursing Services investigates all discrepancies in controlled medication reconciliation to determine the cause and identify any responsible parties, and reports the findings to the Administrator. d. The Director of Nursing Services consults with the provider pharmacy and the Administrator to determine whether further action is indicated...."</p> <p>This deficient practice was corrected by 10/10/23 after the facility implemented a systemic plan that included the following actions: a facility wide controlled substance and correlating reconciliation sheet audit was performed, residents pain assessments, a review of controlled substance medication administration record administered by LPN 6, electronic medical records reviewed for Health Center West to ensure that reconciliation sheets properly uploaded, a meeting with the staffing agency regarding policies and procedures for contracted employees, education provided to all licensed</p> | F 602 | | | |

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| F 602 | Continued From page 8 staff regarding controlled substances and abuse/neglect including agency licensed staff and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI). This citation relates to Complaint IN00419428. 3.1-28(a) | F 602 | | |