STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANSION ON MAIN, THE	1420 EAST MAIN STREET NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: December 6 and 7, 2021. Facility number: 013994 Residential Census: 97 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 9, 2021.	R 0000	Please accept this submission of our Plan of correction for R 0296. It is prepared and submitted because of requirement under state and federal law. Please find enclosed the plan of correction for the survey ending December 7, 2021. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests a desk review for compliance. Should additional information be necessary please contact me. Thank You for your time	
R 0296 Bldg. 00	410 IAC 16.2-5-6(b) Pharmaceutical Services - Noncompliance (b) The facility shall maintain clear written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on observation, record review, and interview, the facility failed to ensure safe and appropriate administration of medications related to a narcotic medication and insulin pen administration, for 2 of 5 residents observed for medication administration. (Residents 5 and 9) Findings include: 1. During an observation of medication administration for Resident 5, on 12/6/21 at 11:10	R 0296	*What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;* Resident # 5 insulin pens were checked and primed to ensure pens were free from any air bubbles. Resident # 9, medication times were adjusted to meet resident's preference. Residents had no negative outcomes by this	12/19/2021

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

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	a.m., LPN (Licensed Practical Nurse) 3 checked the resident's MAR (Medication Administration Record) and placed a novofine needle onto the resident's insulin pen. She indicated the pen did not need to be primed, before going into the resident's room, and administering 8 units of insulin to the resident in his left arm. The clinical record for Resident 3, was reviewed on 12/7/21 at 9:29 a.m., diagnosis included, but was not limited to, diabetes mellitus type 2. The physician's order, dated 11/25/19, indicated to administer 8 units of novolog flexpen three times daily before meals. During an interview, on 12/7/21 at 10:00 a.m., the DON (Director of Nursing) indicated she would expect staff to follow manufacturer guidelines, pens should be primed prior to giving insulin, we educate them to prime pens with 2 units prior to administration. The novofine disposable safety needle instruction pamphlet, provided on 12/7/21 at 9:00 a.m., included, but was not limited to, "... 3. Checking the Flow (air shot) Always check the flow in each delivery device before each injection by performing an air shot. Follow the procedure described in the delivery device instruction leaflet. A drop of liquid should appear at the needle tip; if not, repeat until liquid appears at the needle tip ..." 2. During an observation of medication administration for Resident 9, on 12/6/21 at 11:20 a.m., LPN 3 checked the resident's MAR and pulled one clonazepam 0.5 mg tablet from the narcotic drawer and placed it in a plastic cup to administer to the resident. She went into the residents room and set the medication down on		deficient practice. *How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;* Residents who receive routine insulin have the potential to be affected. All nurses will be educated on the method of insulin delivery by priming insulin pens prior to administration., and the removal of medications if resident refuses one or more of medications at scheduled administration time. At that time Residents doctor will be notified of refusal. This education began on 12/7/21 and will be completed on 12/19/21. Any newly hired Nurses and or QMA, will be educated on this process during orientation. *What measures will be put into place or what systematic changes the facility will make to ensure that the deficient practice does not recur;* The Director of Nursing (DON) will ensure that all nurses have completed education on the method of insulin delivery by priming insulin pens and medication refusals during orientation, and will ensure this standard practice is being met at all times.	

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	the bedside table. A cup full of several pills was observed to be sitting on the bedside table. During an interview, on 12/6/21 at 11:24 a.m., LPN 3 indicated they left the resident's medications on his bedside table for him. He did not wake up until almost noon every day. The medications left on the table at that time were his 8:00 a.m. medications. She had taken them in earlier in the day. He would normally take them when he woke up. She believed and hoped he would take the second dose of clonazepam, she had just taken in, at least a while later and not take both doses at the same time. They should probably look at adjusting the resident's medication schedule to suit the schedule he was on. The clinical record for Resident 9 was reviewed, on 12/7/21 at 9:39 a.m., diagnoses included, but were not limited to, HIV (human immunodeficiency virus), type 2 diabetes, chronic kidney disease (CKD), heart disease, major depressive disorder, benign prostatic hyperplasia (BPH), GERD (gastro-esophageal reflux disease), generalized anxiety disorder, insomnia, ataxia, and type 2 diabetes mellitus with diabetic neuropathy. The resident's MAR, indicated the resident received the following medications on 12/6/21 upon rising; abacavir 300 mg once daily, amantadine 100 mg every other day, aspirin 81 mg once daily, atorvastatin 20 mg daily, citalopram 20 mg daily, clonazepam 0.5 mg three times daily, diltiazem 240 mg ER daily, furosemide 30 mg daily, isosorbide mononitrate 30 mg ER daily, lamivudine 100 mg daily, omeprazole 40 mg daily, probiotic 250 mg twice daily, tamsulosin 0.4 mg daily, and tivicay 50 mg daily. The resident's MAR, indicated the resident		*How the corrective action(s) will be monitored to ensure the deficien*t practice will not recur, i.e. *what quality assurance program will be put into place;* The DON will complete five random audits weekly for four weeks beginning on 12/15/21, then biweekly for one month and then monthly for three months. A review of findings will be discussed with Administrator weekly for four weeks beginning 12/15/21, then biweekly for one month and then monthly for three months. All completed audits will be discussed in facility Quality Assurance meeting to determine if audits can stop if zero negative findings are determined. *By what date the systemic changes will be completed.* *12/19/21*	

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	received clonazepam 0.5 mg three times a day. The resident's controlled substances inventory record indicated the resident had received a dose of clonazepam 0.5 mg at 8:00 a.m. and 12:00 p.m. The 8:00 a.m. dose was still sitting on the residents table when the 12:00 p.m. dose was left in the resident's room. The resident's self-administration evaluation indicated the resident could not be considered capable of self-administration of medications. During an interview, on 12/7/21 at 10:02 a.m., the DON indicated she was not aware of the resident not taking his medications. If they had knowledge of it they should be checking with their doctor and letting them know. Upon rising medications were scheduled for between 7:30 a.m. and 11:00 a.m. She would have held onto the residents next dose of clonazepam and notified his doctor to make sure they knew what he was doing and speak with the resident. She wouldn't want him to take all of the medications at one time. The Medication Management - Medication Administration policy, last revised 5/13/21, provided on 12/7/21 at 9:50 a.m., included, but was not limited to, " ... The administration of medications shall be as ordered by the resident's physician and shall be supervised by a licensed nurse on the premises ... C. Follow the "Six Rights" of administration ... 4. Right Time ... E. Keep unsecured medications within eyesight at all times ... 21. If an alert and oriented resident refuses one or more medication(s) at the scheduled administration time, the resident's right to refuse will be honored. The nurse or qualified medication aide should attempt to identify the reason for refusal ... 23. Refused medication(s) will			

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	be disposed of in accordance with facility policy ... 25. Medication refusal will be reported to the Director of Health Services, who will be responsible for monitoring the number of refusals, and determining when the resident's attending physician will be notified of the refusal(s) ... 29. The Director of Health Services will be notified when prescribed medications are not available to be administered at the scheduled time. The Director of Health Services will be responsible for investigating the reason medications(s) are not available, and for taking corrective actions to ensure medications are available as prescribed ..."			