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	01/09/2024

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CLARKSVILLE SENIOR LIVING LLC	400 HUNTER STATION ROAD SELLERSBURG, IN 47172

(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 the Investigation of Complaint IN00422633. Complaint IN00422633 - No deficiencies related to the allegation are cited. Unrelated deficiencies are cited. Survey dates: January 8 and 9, 2024 Facility number: 013841 Residential Census: 103 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on January 16, 2024.	R 0000	Preparation and submission of this statement of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or of the correctness of the conclusion stated on the statement of deficiencies. The statement of correction is prepared and submitted solely because of requirements under state and federal laws. We cordially request a desk review regarding the alleged deficiencies in lieu of an revisit.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on interview and record review, the facility failed to ensure as needed narcotics, administered by a QMA (Qualified Medication Aide) were authorized and pain assessments completed by a licensed nurse for 5 of 8 residents reviewed for medication administration. (Residents D, E, F, G	R 0246	R246 **Corrective Action(s) for Residents Affected by the Deficient Practice** No residents were affected by the Deficient practice. Residents D,	02/02/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy Jones	Executive Director	01/23/2024

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	and H) Findings include: 1. The clinical record for Resident D was reviewed on 1/8/24 at 12:15 p.m. The diagnoses included, but was not limited to, osteopenia and acute kidney failure. The physician's order, dated 8/21/19 indicated the resident was to receive Percocet (narcotic pain medication) 5-325 mg (milligrams) twice daily as needed for moderate pain. Review of the December 2023 controlled drug record indicated QMA (Qualified Medication Aide) 3 administered the as needed narcotic pain medication on the following dates and times: -12/02/23 at 12:00 a.m. -12/04/23 at 12:00 a.m. -12/07/23 at 12:00 a.m. -12/08/23 at 10:00 p.m. -12/11/23 at 12:00 a.m. -12/13/23 at 12:00 a.m. The clinical record lacked documentation of a licensed nurse assessment and authorization for the administration of the as needed medication. During an interview on 1/9/24 at 12:42 p.m., LPN (Licensed Practical Nurse) 4 indicated the as needed narcotics, prior to administration from a QMA, required authorization and an assessment by a licensed nurse. Currently the facility did not have any staff working as a QMA. Review of QMA 3's record of annual inservice training indicated she was education on medication and narcotic administration on 8/20/23		E, F, H, and G narcotics orders were reviewed after pain assessments were completed on 12/14/2023. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice; however, none were affected. All residents with narcotics ordered were reviewed and service care plans updated as needed to reflect resident needs. **Measures to Ensure the Deficient Practice Does Not Recur** Staff will be educated on PRN medication policy and procedure as well as QMA scope of practice related to prn medication nurse authorization. Education will be presented by regional director of Clinical Services, the Wellness Director and/or the Executive Director by 2/1/2024. Newly hired Nurses and QMAs will be educated during orientation by the Wellness Director and/or the Executive Director. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Wellness Director and/or the Executive Director will review the narcotic log to ensure any prn medications signed out by a QMA has documentation from a nurse authorizing the administration and effectiveness. The audit will	

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	and 11/15/23. The QMA was terminated in December 2023. On 1/9/24 at 12:39 p.m., the Executive Director provided a current copy of the document titled "PRN Medications" dated 6/2014. It included, but was not limited to, "Policy...PRN Medications are those medications given to a resident on an "as needed basis"...Procedure...When it is determined that a resident requires a PRN medication, proper administration medication procedures must be followed...PRN medications may be administered only upon authorization by a licensed nurse...QMA's must document who authorized administration...." 2. The clinical record for Resident E was reviewed on 1/8/24 at 12:23 p.m. The diagnosis included, but was not limited to, Huntington's disease. The physician's order, dated 10/26/23, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 mg (milligrams) every 8 hours as needed for pain. Review of the October 2023 and December 2023 controlled narcotic count sheet indicated QMA 3 administered the following as needed narcotic pain medication on the following dates and times: -10/28/23 at 7:00 a.m. and 3:00 p.m. -12/02/23 at 6:00 a.m. -12/03/23 at 12:00 a.m. -12/08/23 at 6:00 a.m., 1:00 p.m. and 8:00 p.m. -12/13/23 at 12:00 a.m. The clinical record lacked documentation of a licensed nurse assessment and authorization for the administration of the as needed medication.		include 5 residents with prn medications. The audit will be completed 3 times weekly for 4 weeks then 2 times weekly for 4 weeks then weekly for 4 weeks. The Executive Director will review results with the Quality Assurance committee monthly. If 100% compliance is not achieved, the Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

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	3. The clinical record for Resident F was reviewed on 1/8/24 at 1:02 p.m. The diagnoses included, but were not limited to, anxiety and chronic obstructive pulmonary disease. The physician's order, dated 4/1/22, indicated the resident was to receive Hydrocodone-acetaminophen 5-325 mg ever 6 hours as needed for pain. The physician's order, dated 6/8/23, indicated the resident was to receive Hydrocodone-acetaminophen 5-325 mg every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. routinely. Review of the December 2023 controlled narcotic count sheet indicated QMA 3 administered the as needed pain medication on 12/10/23 at 9:00 p.m. and 12:13/23 at 10:00 p.m. The clinical record lacked documentation of a licensed nurse assessment and authorization for the administration of the as needed medication. 4. The clinical record for Resident G was reviewed on 1/8/24 at 12:26 p.m. The diagnoses included, but were not limited to, fibromylagia and chronic pain. The physician's order, dated 11/22/22,, indicated the resident was to receive Hydrocodone-acetaminophen 7.5-325 mg every 8 hours as needed for pain. Review of the December 2023 controlled narcotic count sheet indicated QMA 3 administered the as needed medication on the following dates and times: -12/04/23 at 12:00 a.m.			

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	-12/07/23 at 12:00 a.m. -12/08/23 at 10:00 p.m. -12/13/23 at 12:00 a.m. The clinical record lacked documentation of a licensed nurse assessment and authorization for the administration of the as needed medication. 5. The clinical record for Resident H was reviewed on 1/8/24 at 12:30 p.m. The diagnosis included, but was not limited to, osteoarthritis. The physician's order, dated 11/10/23, indicated the resident was to receive Tramadol HCL 50 mg every 6 hours as needed for pain. Review of the November 2023 controlled narcotic record indicated QMA 3 administered the as needed pain medication on 11/15/23 at 11:00 a.m. and 11/16/23 at 11 a.m. The clinical record lacked documentation of a licensed nurse assessment and authorization for the administration of the as needed medication.			
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on interview and record review, the facility failed to ensure medication errors did not occur for 3 of 8 residents reviewed for medication errors. (Resident D, F, and K) Findings include:	R 0247	**R247** **Corrective Action(s) for Residents Affected by the Deficient Practice** No residents were affected by the Deficient practice. Residents D, F and K medication errors were	02/02/2024

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	1. The clinical record for Resident D was reviewed on 1/8/24 at 12:15 p.m. The diagnoses included, but was not limited to, osteopenia and acute kidney failure. Review of the resident's November 2023 controlled drug record indicated the resident was to receive Percocet (narcotic pain medication) 5-325 mg (milligrams) once daily in the morning and two tablets at bedtime. The November 2023 controlled drug record indicated QMA (Qualified Medication Aide) 3 administered 2 doses to the resident on 11/24/23. The clinical record lacked documentation as to why the resident received 2 doses rather than the one scheduled dose. During an interview on 1/9/24 at 12:42 a.m., LPN (Licensed Practical Nurse) 4 indicated when she spoke with QMA 3 regarding the 2 doses, QMA 3 indicated she gave it to the resident because she was told by the resident that she missed a dose. QMA 3 should not have given the additional dose. On 1/9/24 at 12:39 p.m., the Executive Director provided a current copy of the document titled "Medication Administration" dated 6/2014. It included, but was not limited to, "Staff Member Administration Procedure...No medication shall be given to any resident unless ordered by a physician...." 2. The clinical record for Resident F was reviewed on 1/8/24 at 1:02 p.m. The diagnoses included, but were not limited to, anxiety and chronic obstructive pulmonary disease.		reported to the APRN during investigation and pain interview/assessment was completed to ensure residents were stable. Notification was completed by Wellness director on 12/14/2024. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice; however, none were affected. All residents with narcotics ordered were reviewed and service care plans updated as needed to reflect resident needs. **Measures to Ensure the Deficient Practice Does Not Recur** Staff will be educated on Medication Administration policy and procedure including following physician's orders and physician notification for medication errors. Education will be presented by regional director of Clinical Services, the Wellness Director and/or the Executive Director by 2/1/2024. Newly hired Nurses and QMAs will be educated during orientation by the Wellness Director and/or the Executive Director. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Wellness Director and/or the Executive Director will audit the narcotic medication administration records to ensure medications are	

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	The physician's order, dated 6/8/23, indicated the resident was to receive Hydrocodone-acetaminophen 5-325 mg every 6 hours at 12:00 a.m., 6:00 a.m., 12:00 p.m. and 6:00 p.m. routinely. Review of the September 2023 controlled drug record indicated QMA 3 signed out and administered the medication doses as follows: -9/15/23 at 12:00 a.m. and 6:00 a.m. (QMA 3 clocked out and left the facility at 6:44 p.m. on 9/14/23 and did not return to the facility until 9/15/23 at 7:40 a.m.) Review of the November 2023 controlled drug record indicated QMA 3 signed out and administered the medication doses on the following dates/times: -11/26/23 at 12:00 a.m. (QMA 3 clocked out and left the facility at 9:00 p.m. on 11/25/23 and did not return to the facility until 6:23 p.m. on 11/26/23) -11/27/23 at 12:00 a.m. (QMA clocked out and left the facility at 8:44 p.m. on 11/26/23 and did not return to the facility until 7:38 a.m. on 11/27/23) Review of the December 2023 controlled drug record indicated QMA 3 signed out and administered the medication doses on the following dates/times: -12/03/23 at 12:00 a.m. (QMA 3 clocked out and left the facility at 9:48 p.m. on 12/2/23 and did not return to the facility until 6:26 p.m. on 12/3/23. -12/9/23 at 12:00 a.m. and 6:00 a.m. (QMA 3 clocked out and left the facility at 9:12 p.m. on 12/8/23 and did not return to the facility until 12/10/23 at 6:19 p.m.) -12/13/23 at 12:00 a.m. (QMA 3 clocked out and		given timely and if medications are not given at scheduled time, notification is made to physician with documentation completed in the resident's chart. The audit will include 5 residents with narcotic orders. The audit will be completed 3 times weekly for 4 weeks then 2 times weekly for 4 weeks then weekly for 4 weeks. The Executive Director will review results with the Quality Assurance committee monthly. If 100% compliance is not achieved, the Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

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	left the facility on 12/12/23 at 10:10 p.m. and did not return to the facility until 12/13/23 at 7:33 a.m.) During an interview on 1/9/24 at 12:42 p.m., LPN (Licensed Practical Nurse) 3 indicated when she spoke to QMA 3 about Resident F, she told her she gave the narcotics before she left the facility and would sign them out in the system when she got home as she had access to the medication administration records. She wrote QMA 3 up for medication errors, not following orders and giving medications early on her termination paperwork. 3. The clinical record for Resident K was reviewed on 1/8/24 at 12:38 p.m. The diagnoses included, but were not limited to, spinal stenosis and degenerative joint disease. The physician's order, dated 1/16/23, indicated the resident was to receive Hydrocodone-acetaminophen 5-325 mg twice daily at 8:00 a.m. and 8:00 p.m. Review of the December 2023 controlled drug record indicated QMA 3 administered the medication at the following dates and times: -12/3/23 at 2:00 p.m. -12/8/23 at 2:00 p.m. The clinical record lacked a physician order to administer the medication at 2:00 p.m. on 12/3/23 and 12/8/23.			
R 0306 Bldg. 00	410 IAC 16.2-5-6(g)(1-9) Pharmaceutical Services - Noncompliance (g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or			

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	destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on interview and record review, the facility failed to ensure narcotics were accurately disposed/destroyed by two licensed staff members for 4 of 8 residents reviewed for pharmacy services. (Residents E, G, L, and M) Findings include: 1. The clinical record for Resident E was reviewed on 1/8/24 at 12:23 p.m. The diagnosis included, but was not limited to, Huntington's disease. The physician's order, dated 10/26/23, indicated the resident was to receive Hydrocodone-Acetaminophen (narcotic pain medication) 5-325 mg (milligrams) every 8 hours as needed for pain. Review of the December 2023 controlled narcotic count sheet indicated on 12/8/23, QMA (Qualified Medication Aide) 3 dropped and wasted the tablet that was dropped. The controlled narcotic count sheet lacked a 2nd signature/witness for the destruction of the narcotic medication.	R 0306	**R306** **Corrective Action(s) for Residents Affected by the Deficient Practice** No residents were affected by the Deficient practice. Residents E, G, L and M were noted to have medications that were wasted/destructed on the narcotic log. Notification to the physicians and responsible parties were completed by 12/15/2024 by the executive director during the investigation. **Corrective Action(s) for Other Residents Potentially Affected** All residents have the potential to be affected by this deficient practice; however, none were affected. All residents' narcotic logs were reviewed by Executive Director and if any wasted or destructed medications, the families and physician were notified. **Measures to Ensure the**	02/02/2024

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	During an interview on 1/9/24 at 12:32 p.m., LPN (Licensed Practical Nurse) 4 indicated to staff member can destroy wasted narcotics independently. QMA 3 indicated LPN 4 that she was unaware that she could not destroy medications independently. Review of the undated Nurse/QMA Narcotic/Medication Administration Inservice sheet included, but was not limited to, "No one nurse or QMA can destroy Narcotics by themselves...." 2. The clinical record for G was reviewed on 1/8/24 at 12:26 p.m. The diagnoses included, but were not limited to, chronic pain and fibromyalgia. The physician's order, dated 4/18/23, indicated the resident was to receive Hydrocodone-Acetaminophen 7.5 - 325 mg three times a day at 6:00 a.m., 12:00 p.m. and 6:00 p.m. and every 8 hours as needed. The September 2023 controlled narcotic count sheet indicated on 9/17/23, QMA 3 wasted one tablet with documentation that it had already been pulled for administration. The controlled narcotic count sheet lacked a 2nd signature/witness for the destruction of the narcotic medication. The December 2023 controlled narcotic sheet indicated on 12/13/23 at 12:00 a.m., QMA 3 wasted a tablet without documentation as to why. The controlled narcotic count sheet lacked a 2nd signature/witness for the destruction of the narcotic medication. 3. The clinical record for Resident L was reviewed on 1/8/24 at 12:42 p.m. The diagnoses included,		**Deficient Practice Does Not Recur** Staff will be educated on the Narcotic destruction policy and procedure including narcotic log, narcotic card count sheet, physician notification, and 2 licensed staff to destroy. Education will be presented by regional director of Clinical Services, the Wellness Director and/or the Executive Director by 2/1/2024. Newly hired Nurses and QMAs will be educated during orientation by the Wellness Director and/or the Executive Director. **The Monitoring Process to Ensure the Deficient Practice Does Not Recur** The Wellness Director and/or the Executive Director will audit the narcotic log sheets to ensure appropriate documentation per the policy. The audit will include 5 residents with narcotic orders. The audit will be completed 3 times weekly for 4 weeks then 2 times weekly for 4 weeks then weekly for 4 weeks. The Executive Director will review results with the Quality Assurance committee monthly. If 100% compliance is not achieved, the Quality Assurance committee will determine the need for further revisions or corrective actions as well as a need to change the frequency and length of continued audits.	

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	but were not limited to, arthritis and neuropathy. The physician's order, dated 10/30/23, indicated the resident was to receive Hydrocodone-Acetaminophen 5-325 mg every 6 hours as needed for pain. The December 2023 narcotic count sheet indicated on 12/6/23 at 8:00 p.m., indicated QMA 3 wasted the dose due to it was accidentally pulled for administration. The controlled narcotic count sheet lacked a 2nd signature/witness for the destruction of the narcotic medication. 4. The clinical record for Resident M was reviewed on 1/8/24 at 12:50 p.m. The diagnoses included, but were not limited to, osteoarthritis and low back pain. Review of the progress note, dated 8/11/23 at 6:08 p.m., indicated the resident was sent to the hospital for evaluation due to a fall, and on 9/20/23 at 12:00 p.m., the resident returned to the facility from the hospital. Review of the August 2023 narcotic count sheet dated 8/17/23 at 8:00 a.m., indicated QMA 3 pulled one of the doses for administration. There was no documentation on the narcotic count sheet that the medication had been wasted. During an interview on 1/9/24 at 12:42 p.m., LPN 4 indicated when it was brought to her attention, she spoke with QMA 3 about it. QMA 3 told LPN 4 she pulled the medication by accident and was going to wait for the oncoming nurse to waste it with her. She did not and wasted it herself.			