STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND ST INDIANAPOLIS, IN 46250

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure accurate reconciliation of narcotic medications and assure signatures of dispensing nurses were present on the narcotic control record for 3 of 5 residents reviewed for medication administration. (Residents H, L, and R) Findings include: An observation of medication administrations was conducted with License Practical Nurse (LPN) 1 on 8/3/20 at 11:30 a.m. After observing 6 residents' medication administrations, LPN 1 was observed pulling and preparing Resident R's medications. She had pulled the medication card for Resident R labeled 60 milligrams of [MEDICATION NAME] out of the narcotic box in the medication cart. She then popped the pill in a cup and administered the medication to Resident R. After, she returned to the medication cart and pulled the narcotic reconciliation binder. She then turned to Resident R's [MEDICATION NAME] Controlled Drug Administration Record. LPN 1 indicated she had already signed on the record she had administered the 60 milligrams of [MEDICATION NAME] to Resident R earlier in the morning. Resident R's [MEDICATION NAME] was routine and received the [MEDICATION NAME] at the same time daily. 1. The clinical record for Resident R was reviewed on 8/4/20 at 9:00 a.m. The [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The 4/27/20 Controlled Drug Administration Record of 60 milligrams of [MEDICATION NAME] for Resident R indicated the following: 5/2/20 at 6:00 a.m., 1 pill of 60 milligrams of [MEDICATION NAME] was removed from the medication card and the remaining count was 21 pills. 5/2/20 at 1:00 p.m., 1 pill of 60 milligrams of [MEDICATION NAME] was removed from the medication card and the remaining count was 20 pills. There was notation the 5/2/20 at 1:00 p.m., pill was dropped and wasted. 5/2/20 at 1:00 p.m., 1 pill of 60 milligrams of [MEDICATION NAME] was removed from the medication card and the remaining count was 21 pills. 5/2/20 at 10:00 p.m. 1 pill of 60 milligrams of [MEDICATION NAME] was removed from the medication card and the remaining count was 19 pills. 5/2/20 at no time recorded indicated with no staff signature the remaining count was 18 pills. An interview was conducted with the Director of Nursing (DON) on 8/4/20 at 12:17 p.m. She indicated the staffs' calculations were incorrect on the record. The staff do count the narcotics on the medication carts at each shift change. 2a. The clinical record for Resident H was reviewed on 8/3/20 at 11:00 a.m. The [DIAGNOSES REDACTED]. A Quarterly MDS (Material Data Set) Assessment, dated 7/12/20, indicated the resident was cognitively intact. A physician's orders [REDACTED]. This order was discontinued on 6/10/20. The 6/8/20 Controlled Drug Administration Record of 10 milligrams of [MEDICATION NAME] for Resident H indicated she had received 1 tablet of 10 milligrams of [MEDICATION NAME] on 6/10/20 at 6:00 a.m., instead of 2 tablets. The Electronic Medication Administration Record (EMR) note dated 6/10/20 at 5:32 a.m., indicated Resident H had only 1 tablet of 20 milligrams of [MEDICATION NAME] to give instead of two tablets. A prescription was required for the pharmacy. The Electronic Medication Administration Record (EMR) dated 6/10/20 at 9:05 a.m., indicated awaiting for pharmacy delivery for the 20 milligrams of [MEDICATION NAME]. 2b. A physician's orders [REDACTED]. This order was discontinued on 7/22/20. A physician's orders [REDACTED]. The 7/24/20 Controlled Drug Administration Record of 2 tablets of 5-325 milligrams of [MEDICATION NAME] for Resident H indicated the following: 7/24/20 at 4:00 p.m., 1 tablet used and total amount remaining was 19 tablets, 7/24/20 at 4:00 p.m., 1 tablet used and total amount remaining was 18 tablets, 7/24/20 at 9:00 p.m., 1 tablet used and total amount remaining was 17 tablets, 7/24/20 at 9:00 p.m., 1 tablet used and total amount remaining was 16 tablets, 7/25/20 at 12:00 a.m., 2 tablets used and total amount remaining was 14 tablets, 7/25/20 at 6:00 a.m., 2 tablets used and total amount remaining was 12 tablets, 7/25/20 at 6:00 a.m., indicated corrected count. Total remaining was 14 tablets, No recorded 7/25/20 12:00 p.m., dosage, 7/25/20 at 6:00 p.m., 2 tablets used and total amount remaining was 12 tablets. An interview was conducted with Resident H on 8/3/20 at 12:00 p.m. She indicated her pain medication was always running out and at times she did not get her scheduled pain medications. There were incidents that she would ask for her pain medication, because she had not received it. The nursing staff would tell her she did get it. Then the next shift nursing staff would come in and say she was right she had not gotten it. The staff would then administer the pain medication from the previous scheduled time. An interview was conducted with LPN 1 on 8/3/20 at 11:30 a.m. She indicated there was confusion with Resident H's dosages of her pain medications. An interview was conducted with the Corporate Nurse at 8/4/20 at 2:00 p.m. After reviewing of the records, there are discrepancies with Resident H's controlled drug administration records. 3. The clinical record of Resident L was reviewed on 8/4/2020 at 9:52 a.m. His [DIAGNOSES REDACTED]. The clinical record contained a physician's orders [REDACTED]. The July 2020 MAR (Medication Administration Record) was reviewed. The July MAR indicated the [MEDICATION NAME]-[MEDICATION NAME] 10-325 mg had been administered, as ordered, on 7/9/2020. On 8/4/2020 at 12:15 p.m., the DON provided the Controlled Drug Administration Record for the [MEDICATION NAME]- [MEDICATION NAME] 10-325mg tablets, which had been delivered from the pharmacy on 6/17/2020. The Controlled Drug Administration Record was missing the signature of the dispensing nurse for the following dates and times: 7/9/2020 at 9:00 a.m., 7/9/2020 at 1:00 p.m., 7/9/2020 at 5:00 p.m., and 7/9/2020 at 9:00 p.m. During an interview on 8/4/2020 at 2:30 p.m., the DON indicated that the Controlled Drug Administration Record should include the signature of the person who had obtained the narcotic to administer. The controlled substance policy was provided by the DON on 8/4/20 at 3:08 p.m. It indicated .Policy: .The purpose of this policy is to provide a consistent and traceable method to maintain the chain of custody of controlled substances from delivery from the pharmacy to administrating to the resident or to disposal. The policy will be valuable for preventing drug diversions, tracking the chain of custody of controlled substances, accidental or intentional consumption of resident medications as well as provide a safe and environmentally sound method to dispose of controlled substances .II. General b. Scheduled drugs require an inventory count sheet. i. Specific pharmacy delivered sheets are to be used; do no recreate. c. Keep orders with multiple count sheets together in the binder on the cart i. Do not separate the sheets. ii. Doses must be accounted for at all times. III. Administration of Controlled Substances a. Nurses will not change the printed quantities on the count sheets. b. Nurse will verify quantity on the pharmacy invoice or manifest d. Nurse will also verify resident name, drug, time, route and dose. e. Nurse will sign both the MAR and the Drug Count Sheet when administering a controlled substance to a resident . IV. Shift to Shift Chain of Custody Count a. Two nurses will perform the Shift-to-Shift Chain of Custody Count. i. One nurse from the off-going shift will count with the on-coming nurse. ii. The off-going nurse counts the sheets; the on-coming nurse counts the medications. iii. Count will include the number of cards and the number of drugs for each shift count .v. If discrepancies are noted, the on-going nurse will not accept the keys and the supervisor will be notified immediately. vi. Neither nurse may leave the unit until the count discrepancy is resolved. b. Any time the controlled substances keys are exchanged, a full counting must occur. i. Any unresolved discrepancies will result in contacting the supervisor and/or DON if unresolved This Federal Tag relates to

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND ST INDIANAPOLIS, IN 46250

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 0755 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) complaint IN 977. 3.1-25(b)(3) 3.1-25(e)(3)
F 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's pain medication was not administered in excessive dosages, ensure antianxiety medication was given as ordered, and ensure antianxiety medication was not given without an active physician order for [REDACTED]. (Resident H, P and Q) Findings include: 1. The clinical record for Resident Q was reviewed on 8/4/20 at 11:18 a.m. The [DIAGNOSES REDACTED]. A physician's order, dated 7/20/20, indicated the following, .[MEDICATION NAME] (antianxiety medication) Tablet 1 MG (milligram) .Give 1 tablet by mouth every 4 hours for anxiety The [MEDICATION NAME] order was scheduled and Resident Q did not have an order for [REDACTED]. The medication was scheduled for Resident Q to receive 6 times a day. The narcotic log for Resident Q's [MEDICATION NAME] 1 milligram tablet indicated from 7/20/20 through 8/4/20 the following date(s) the resident did not receive 6 doses of [MEDICATION NAME] administration: 7/21/20, 7/22/20, 7/25/20, 7/28/20, 7/29/20, & 7/31/20. 2. The clinical record for Resident P was reviewed on 8/4/20 at 11:08 a.m. The [DIAGNOSES REDACTED]. A physician's order, with a start date of 10/16/18, indicated the following, .[MEDICATION NAME] Tablet (antianxiety medication) 0.5 MG (milligram) .Give 1 tablet by mouth every 12 hours for anixety (sic) The order was discontinued on 6/25/20 due to Resident Q being hospitalized from [DATE] through 6/29/20. There were no current physician orders on the electronic medication administration record for Resident P's [MEDICATION NAME] tablet upon record review. A CONTROLLED DRUG ADMINISTRATION RECORD was reviewed for Resident P's [MEDICATION NAME] 0.5 milligram tablet order. The medication was administered on 28 occasions after the discontinuation date of 6/25/20. The dates of administration were from 7/2/20 through 8/3/20. An interview conducted, on 8/4/20 at 3:17 p.m., with the Director of Nursing (DON) indicated Resident P's [MEDICATION NAME] order was discontinued on 6/25/20 when she went out to the hospital. The order was not inputted into the electronic medical record upon her return to the facility. That resulted in no active order in the computer for administration. The expectations are for staff to ensure an active order is present in the computer system for the administration of medications. 3. The clinical record for Resident H was reviewed on 8/3/20 at 11:00 a.m. The [DIAGNOSES REDACTED]. A physician's order, dated 7/23/20, indicated Resident H was to receive 2 tablets of 5-325 milligrams of [MEDICATION NAME] four times a day. A Controlled Drug Administration Record indicated Resident H was to receive 1 tablet of 10-325 milligrams of [MEDICATION NAME] 4 times a day. The record indicated Resident H was administered 2 tablets of 10-325 milligrams of [MEDICATION NAME] on the following days and times: 7/23/20 at no time recorded, 7/23/20 at no time recorded, 7/24/20 at 12:00 a.m., and 7/24/20 at 6:00 a.m. An observation was made of the medication cart with the DON and License Practical Nurse (LPN) 1 on 8/4/20 at 12:21 p.m. The cart contained Resident H's medication cards. There were 5-325 milligrams of [MEDICATION NAME] tablets for Resident H observed in the cart. An interview was conducted with LPN 1 at 8/4/20 at 12:22 p.m. She indicated there was some confusion on Resident H's dosages of her [MEDICATION NAME]. Resident H had been receiving 5-325 milligrams of [MEDICATION NAME]. The medical provider had written a new prescription for the resident's [MEDICATION NAME] and directly faxed the prescription to the pharmacy. The medical provider had written Resident H was to receive 1 tablet of 10-325 milligrams instead of the 5-325 milligrams. The staff received the [MEDICATION NAME] from the pharmacy and called the medical provider for clarification. He ordered to administer 1 tablet of the 10-325 milligrams of [MEDICATION NAME] until the medication card was completed. Then the resident would go back to receiving the 2 tablets of 5-325 milligrams of [MEDICATION NAME]. The 10-325 milligrams was completed, and the resident had went back to receiving the 5-325 milligrams. There was no physician order in Resident H's clinical record indicating 1 tablet of 10-325 milligrams of [MEDICATION NAME] was ordered to be administered to the resident. An interview was conducted with the DON on 8/4/20 at 3:07 p.m. She indicated Resident H's controlled drug record for the 10-325 milligrams of [MEDICATION NAME] did indicate the resident had received 2 tablets instead of 1 tablet 4 times in error. The staff should have put the order in the system. The controlled substance policy was provided by the DON on 8/4/20 at 3:08 p.m. It indicated .Policy: .The purpose of this policy is to provide a consistent and traceable method to maintain the chain of custody of controlled substances from delivery from the pharmacy to administrating to the resident or to disposal. The policy will be valuable for preventing drug diversions, tracking the chain of custody of controlled substances, accidental or intentional consumption of resident medications as well as provide a safe and environmentally sound method to dispose of controlled substances. Failure to document controlled substances on MAR is a medication error and must be investigated .II. General .ii. Doses must be accounted for at all times .III. Administration of Controlled Substances a. Nurses will not change the printed quantities on the count sheets. b. Nurse will verify quantify on the pharmacy invoice or manifest d. Nurse will also verify resident name, drug, time, route and dose. e. Nurse will sign both the MAR and the Drug Count Sheet when administering a controlled substance to a resident This Federal tag relates to complaint IN 977. 3.1-48(c)(2)