STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155094	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary Healthcare Center	2201 Cason St Lafayette, IN 47904

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32362 Based on interview and record review, the facility failed to ensure a resident received medications per the physician's order for 1 of 1 resident reviewed for quality of care. (Resident H) This deficient practice was corrected on 6/10/24, prior to the start of the survey, and was therefore past noncompliance. Finding includes: The clinical record for Resident H was reviewed on 11/14/24 at 12:30 p.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, chronic kidney disease, and anxiety. The resident had a severe cognitive deficit and was receiving hospice care. A review of the Medication Administration Record (MAR) indicated the resident did not receive her ordered dose of Morphine concentrate (a pain medication) every 6 hours on 5/25/24 at 10:00 p.m., 5/26/24 at 4:00 a.m., 10:00 a.m., 4:00 p.m., 10:00 p.m., and on 5/27/24 at 4:00 a.m., 10:00 a.m., 4:00 p.m., 10:00 p.m. The MAR indicated the medication was not available for administration. The nursing notes did not indicate the resident had been assessed for pain on 5/25, 5/26, and 5/27/24. The physician had been notified. Family had not been notified. Hospice had not been notified. The Emergency Drug Kit (EDK) medication box had not been utilized. During an interview, on 11/13/24 at 3:39 p.m., Resident H could not answer questions other than yes or no questions. The resident did indicate she had no pain. During an interview, on 11/13/24 at 2:10 p.m., the Regional Clinical Support nurse indicated the errors were made by the facility staff and two (2) staff members had been terminated for not following the policies and procedures of the facility. During an interview, on 11/13/24 at 4:15 p.m., the Regional Clinical Support nurse indicated there was no pain assessment documented for the resident on 5/25, 5/26 and 5/27/24. The MAR indicated the resident was given routine Tylenol three times daily on 5/25, 5/26 and 5/27/24. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Preparation and General Guidelines, revised 11/2018 and provided by the Regional Clinical Support nurse on 11/14/24 at 11:13 a.m., indicated .The individual who administers the medication dose records the administration on the resident's MAR directly after medication is given A current facility policy, titled Guidelines for Narcotic Count, revised 8/2016 and provided by the Regional Clinical Support nurse on 11/14/24 at 11:11 a.m., indicated .Each controlled drug shall have a corresponding count sheet to track distribution. 2. The narcotic book shall contain a sheet providing space for the off going and oncoming nursing staff to record their signatures indicating the narcotics has been reviewed .Both staff members shall sign that the narcotic count is accurately reconciled The deficient practice was corrected by 6/10/24 after the facility implemented a systemic plan which included a thorough investigation, staff education, and audits of the shift-to-shift controlled substance counting, disposal of controlled substances, and controlled substance documentation. This citation relates to Complaint IN00436486. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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. 32362 Based on observation, interview and record review, the facility failed to ensure medications were documented as given, medications were disposed of properly, narcotic medication logbooks reflected the medication given to residents and medication records were reconciled for 3 of 5 medication carts reviewed. This deficient practice was corrected on 6/10/2024, prior to the start of the survey, and was therefore past noncompliance. Finding includes: 1. The narcotic sign-in and sign-out record book, from 5/1/24 thru 6/9/24 was missing 66 nursing staff signatures. 2. The medication destruction logbook, from 4/14/24 thru 6/15/24, had 24 errors. There were 7 dates missing, 11 resident names missing, 3 quantity amounts missing, 2 nursing signatures missing, and one entry was not log into the book. 3. The narcotic logbook entries did not match the resident Medication Administration Record (MAR) for 14 residents. The number of errors was 61 for the period of 4/4/24 thru 6/6/24. The narcotic book indicated 32 medications were withdrawn. The MAR did not reflect the administration of the medications. The MAR indicated 29 medications were administered. The narcotic record logs did not indicate the medications were withdrawn for the medication administration. During an interview, on 11/13/24 at 2:10 p.m., the Regional Clinical Support nurse indicated the documentation errors were made by the staff. She indicated two (2) staff members had been terminated for not following policies and procedures of the facility. A current facility policy, titled Disposal of Medications and Medication - Related Supplies, revised 11/2018 and provided by Regional Clinical Support nurse on 11/14/24 at 11:11 a.m., indicated .The person witnessing the destruction ensures that the following information is entered on the individual controlled substance accountability record/book: 1) Date of destruction. 2) Resident's name. 3) Name and strength of medication. 4) Prescription number. 5) Amount of medication destroyed. 6) signature of witnesses A current facility policy, titled Preparation and General Guidelines, revised 11/2018 and provided by Regional Clinical Support nurse on 11/14/2024 at 11:13 a.m., indicated .The individual who administers the medication dose records the administration on the resident's MAR directly after medication is given A current policy, titled Guidelines for Narcotic Count, revised 8/2016 and provided by Regional Clinical Support nurse on 11/14/2024 at 11:11 a.m., indicated .Each controlled drug shall have a corresponding count sheet to track distribution. 2. The narcotic book shall contain a sheet providing space for the off going and oncoming nursing staff to record their signatures indicating the narcotics has been reviewed .Both staff members shall sign that the narcotic count is accurately reconciled (continued on next page)

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(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	The deficient practice was corrected by 6/10/2024, after the facility implemented a systemic plan which included a thorough investigation, staff education, and audits of the shift-to-shift controlled substance counting, disposal of controlled substances, and controlled substance documentation. This citation relates to Complaint IN00436486. 3.1-25(b)