STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN	98 NORTH 10TH STREET, GREENCASTLE, , 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: July 17 and 18, 2025 Facility number: 013322 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 23, 2025.	R 0000		
R 0300	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(4) (4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration	R 0300	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Autumn Glen as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of	07/19/2025

	date. Based on observation, record review, and interview, the facility failed to ensure medications were disposed of once past the use by date for 1 of 1 medication room observations. Findings include: On 7/17/25 at 11:25 a.m., the refrigerator in the medication room was observed with Licensed Practical Nurse (LPN) 3. There was an opened vial of Aplisol (medication used to test for tuberculosis exposure) with an opened date of 5/9/25. At the same time, LPN 3 indicated she thought the Aplisol was good for three months after it was opened. During an interview, on 7/17/25 at 1:20 p.m., the Director of Nursing (DON) indicated Aplisol was good for 30 days after the opened date, and should have been discarded after 30 days. On 7/17/25 at 2:00 p.m., the DON provided a document titled, "Medication Storage Guidance," dated 2025, and indicated it was the policy currently being used by the facility. The policy indicated, "...Non-Insulin Injectable Medications...Storage Recommendations...Aplisol Injection...Store in the refrigerator...Date when opened		Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies. **R 300** Medications will be disposed of once past the use by date.	

	and discard unused portion after 30 days...." Based on observation, record review, and interview, the facility failed to ensure medications were disposed of once past the use by date for 1 of 1 medication room observations. Findings include: On 7/17/25 at 11:25 a.m., the refrigerator in the medication room was observed with Licensed Practical Nurse (LPN) 3. There was an opened vial of Aplisol (medication used to test for tuberculosis exposure) with an opened date of 5/9/25. At the same time, LPN 3 indicated she thought the Aplisol was good for three months after it was opened. During an interview, on 7/17/25 at 1:20 p.m., the Director of Nursing (DON) indicated Aplisol was good for 30 days after the opened date, and should have been discarded after 30 days. On 7/17/25 at 2:00 p.m., the DON provided a document titled, "Medication Storage Guidance," dated 2025, and indicated it was the policy currently being used by the facility. The policy indicated, "...Non-Insulin Injectable Medications...Storage Recommendations...Aplisol Injection...Store in the refrigerator...Date when opened		1 The Community reviewed each resident's record to determine which residents, if any, could be affected by the alleged deficient practice. 2 All refrigerated medications have been audited to ensure they are not past expiration. All care staff will be in-serviced on the community's policy for medication storage and handling. 3 The Wellness Director or designee will audit medication refrigerators for expired medications weekly for 4 weeks, and monthly for 5 months. 4 Corrective date: 7/19/2025	

	and discard unused portion after 30 days...."			
R 0301	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(5) (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted. Based on observation, record review, and interview, the facility failed to ensure a medication label matched the physician's order for the medication for 1 of 5 medication pass observations (Resident 5). Findings include: On 7/17/25 at 11:20 a.m.,	R 0301	This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Autumn Glen as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer,	07/19/2025

	Licensed Practical Nurse (LPN) 3 prepared Resident 5's medication. A bottle of colesevelam (medication which lowers cholesterol and can manage type two diabetes) 625 milligrams (mg) tablets included a label with directions to administer three tablets of the medication. The label indicated the medication was filled on 1/9/25. LPN 3 prepared one tablet for administration and indicated the physician's order was to administer one tablet of the medication. Prior to administering the medication to Resident 5, LPN 3 verified the physician's order was for one tablet in the resident's medication record. At the same time, LPN 3 indicated there should have been a "directions changed" sticker placed on the bottle's label if the label's instructions were different than the physician's order. Resident 5's record was reviewed on 7/17/25 at 2:11 p.m. Census information indicated the resident was admitted to the facility on 4/17/25. Diagnoses on the resident's profile included, but were not limited to, type two diabetes mellitus and irritable bowel syndrome (disorder affecting the large intestine which changes bowel habits).		director, attorney, or shareholder of the Community or affiliated companies. **R301** Resident 5’s medication label matches the physician’s order. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice 1 All care staff will be in-serviced on the community’s policy for change of orders. 2 The Wellness Director or designee will audit medication carts for proper labeling weekly for 4 weeks, and monthly for 5 months. 3 Corrective date: 7/19/2025	

	A physician's order, dated 4/18/25, indicated colesevelam 625 mg by mouth twice daily for irritable bowel syndrome. During an interview, on 7/17/25 at 1:20 p.m., the Director of Nursing (DON) indicated when a physician's order was different than the medication's label, a "directions changed" sticker should have been placed on the label. During an interview, on 7/17/25 at 1:59 p.m., the DON indicated the resident was admitted to the facility in April 2025, and the colesevelam order was for one tablet since admission. The bottle, with the instructions to administer three tablets, was brought to the facility by the resident when she admitted to the facility On 7/17/25 at 1:56 p.m., the DON provided a document titled, "Change of Orders," dated August 2017, and indicated it was the policy currently being used by the facility. The policy indicated, "...1. If a Resident's physician orders a change in a Resident's medication or treatment, notify the pharmacy of the change. 2. If the order change involves a medication, remove all of the containers with the old directions to be returned to the pharmacy as applicable...Store the medications in a locked cabinet			

	separate from current medications. The pharmacy will deliver new containers with new labels...." Based on observation, record review, and interview, the facility failed to ensure a medication label matched the physician's order for the medication for 1 of 5 medication pass observations (Resident 5). Findings include:			

	On 7/17/25 at 11:20 a.m., Licensed Practical Nurse (LPN) 3 prepared Resident 5's medication. A bottle of colesevelam (medication which lowers cholesterol and can manage type two diabetes) 625 milligrams (mg) tablets included a label with directions to administer three tablets of the medication. The label indicated the medication was filled on 1/9/25. LPN 3 prepared one tablet for administration and indicated the physician's order was to administer one tablet of the medication. Prior to administering the medication to Resident 5, LPN 3 verified the physician's order was for one tablet in the resident's medication record. At the same time, LPN 3 indicated there should have been a "directions changed" sticker placed on the bottle's label if the label's instructions were different than the physician's order. Resident 5's record was reviewed on 7/17/25 at 2:11 p.m. Census information indicated the resident was admitted to the facility on 4/17/25.			

	Diagnoses on the resident's profile included, but were not limited to, type two diabetes mellitus and irritable bowel syndrome (disorder affecting the large intestine which changes bowel habits). A physician's order, dated 4/18/25, indicated colesevelam 625 mg by mouth twice daily for irritable bowel syndrome. During an interview, on 7/17/25 at 1:20 p.m., the Director of Nursing (DON) indicated when a physician's order was different than the medication's label, a "directions changed" sticker should have been placed on the label. During an interview, on 7/17/25 at 1:59 p.m., the DON indicated the resident was admitted to the facility in April 2025, and the colesevelam order was for one tablet since admission. The bottle, with the instructions to administer three tablets, was brought to the facility by the resident when she admitted to the facility On 7/17/25 at 1:56 p.m., the DON provided a document titled, "Change of Orders," dated August 2017, and indicated it was the policy currently being used by the facility. The policy indicated, "...1. If a Resident's physician orders a change in a Resident's medication or			

	treatment, notify the pharmacy of the change. 2. If the order change involves a medication, remove all of the containers with the old directions to be returned to the pharmacy as applicable...Store the medications in a locked cabinet separate from current medications. The pharmacy will deliver new containers with new labels...."			
R 0407	Infection Control - Noncompliance 410 IAC 16.2-5-12(b)(1-4) (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on record review and interview, the facility failed to ensure residents were educated regarding the influenza vaccine and declinations of the vaccine were documented for 2 of 3	R 0407	IDR requested as there is no requirement to document education and refusal of influenza vaccines in resident records for residential care settings. This Plan of Correction is submitted as required under State law. The submission of this Plan of Correction does not constitute an admission on the part of Autumn Glen as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. The submission of this Plan of Correction does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent	07/19/2025

residents reviewed for infection control (Residents 10 and 3).

Findings include:

1. Resident 10's record was reviewed on 7/18/25 at 9:35 a.m. Census information indicated the resident was admitted to the facility on 9/21/23.

Diagnoses on the resident's profile included, but were not limited to, cerebral vascular accident (CVA) (stroke) and chronic obstructive pulmonary disease (COPD) (group of lung diseases that causes breathing problems).

The resident's electronic medical record indicated the influenza vaccine information was "missing."

The resident's paper medical record lacked documentation the resident was offered, received, or declined an influenza vaccine for the 2024-2025 influenza season.

A physician's order, dated 4/2/25, indicated the resident may have the annual influenza vaccine, if not contraindicated.

remedial measures, as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any judicial and/or administrative proceeding on that basis. The Community also submits this Plan of Correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

R407

1. Residents 10 and 3 medical records will be updated to reflect they declined the influenza vaccine.

2. The Community reviewed each resident’s record to determine which residents, if any, could be affected by the alleged deficient practice .

3. All care staff will be educated on vaccine administration and documentation of refusal. In addition, all residents will receive documented vaccine education. Those residents who decline the vaccine medical records will be updated to reflect

	2. Resident 3's record was reviewed on 7/18/25 at 10:05 a.m. Census information indicated the resident was admitted to the facility on 1/30/22. Diagnoses on the resident's profile included, but were not limited to, congestive heart failure (CHF) (chronic condition where the heart does not pump enough blood) and chronic obstructive pulmonary disease (COPD) (group of lung diseases that causes breathing problems). The resident's electronic medical record indicated the influenza vaccine information was "missing." The resident's paper medical record lacked documentation the resident was offered, received, or declined an influenza vaccine for the 2024-2025 influenza season. A physician's order, dated 4/2/25, indicated the resident may have the annual influenza vaccine, if not contraindicated. During an interview, on 7/18/25 at 9:46 a.m., the Director of Nursing (DON) indicated Residents 10 and 3 declined the influenza vaccine, but she was unable to find documentation of their declinations. They documented the residents		the decline. 4. The Wellness Director or designee will audit all influenza vaccine refusals and vaccine education to ensure proper education and documentation were completed. 5. Corrective date: 7/19/2025	

declined on their internal facility influenza vaccine tracker, but there was no documentation in the residents' medical record. The DON was unable to provide documentation the residents received education regarding the influenza vaccine.

During an interview, on 7/18/25 at 10:05 a.m., the DON indicated the facility did not document if residents refused an influenza vaccine or the receipt of their vaccine education because resident vaccines were "encouraged but not required." They held an influenza vaccine clinic each year and posted a clinic sign up with education notices. The clinic would have provided vaccine education to the residents who received the vaccine.

During an interview, on 7/18/25 at 10:31 a.m., the Administrator indicated she handed out influenza vaccine education to each resident and the education was sent out with account statements, however it was not documented. She provided sample influenza vaccine handouts, but was unable to provide documentation the handouts were provided to Resident 10 or documentation of his vaccine declination.

On 7/18/25 at 10:31 a.m., the DON provided an untitled

document, dated August 2023, and indicated it was the policy currently being used by the facility. The facility indicated, "...Flu Vaccine...4. General procedures for ordering and administering vaccine...The Resident...will complete the Flu Consent Form...prior to the administration of the vaccine...Offer the resident...a choice as to whether or not he/she wants to have a flu shot...."

Based on record review and interview, the facility failed to ensure residents were educated regarding the influenza vaccine and declinations of the vaccine were documented for 2 of 3 residents reviewed for infection control (Residents 10 and 3).

Findings include:

1. Resident 10's record was reviewed on 7/18/25 at 9:35 a.m. Census information indicated the resident was admitted to the facility on 9/21/23.

Diagnoses on the resident's profile included, but were not limited to, cerebral vascular accident (CVA) (stroke) and chronic obstructive pulmonary disease (COPD) (group of lung diseases that causes breathing problems).

The resident's electronic medical record indicated the

influenza vaccine information was "missing."

The resident's paper medical record lacked documentation the resident was offered, received, or declined an influenza vaccine for the 2024-2025 influenza season.

A physician's order, dated 4/2/25, indicated the resident may have the annual influenza vaccine, if not contraindicated.

2. Resident 3's record was reviewed on 7/18/25 at 10:05 a.m. Census information indicated the resident was admitted to the facility on 1/30/22.

Diagnoses on the resident's profile included, but were not limited to, congestive heart failure (CHF) (chronic condition where the heart does not pump enough blood) and chronic obstructive pulmonary disease (COPD) (group of lung diseases that causes breathing problems).

The resident's electronic medical record indicated the influenza vaccine information was "missing."

The resident's paper medical record lacked documentation the resident was offered, received, or declined an influenza vaccine for the

2024-2025 influenza season.

A physician's order, dated 4/2/25, indicated the resident may have the annual influenza vaccine, if not contraindicated.

During an interview, on 7/18/25 at 9:46 a.m., the Director of Nursing (DON) indicated Residents 10 and 3 declined the influenza vaccine, but she was unable to find documentation of their declinations. They documented the residents declined on their internal facility influenza vaccine tracker, but there was no documentation in the residents' medical record. The DON was unable to provide documentation the residents received education regarding the influenza vaccine.

During an interview, on 7/18/25 at 10:05 a.m., the DON indicated the facility did not document if residents refused an influenza vaccine or the receipt of their vaccine education because resident vaccines were "encouraged but not required." They held an influenza vaccine clinic each year and posted a clinic sign up with education notices. The clinic would have provided vaccine education to the residents who received the vaccine.

During an interview, on 7/18/25 at 10:31 a.m., the Administrator

	indicated she handed out influenza vaccine education to each resident and the education was sent out with account statements, however it was not documented. She provided sample influenza vaccine handouts, but was unable to provide documentation the handouts were provided to Resident 10 or documentation of his vaccine declination. On 7/18/25 at 10:31 a.m., the DON provided an untitled document, dated August 2023, and indicated it was the policy currently being used by the facility. The facility indicated, "...Flu Vaccine...4. General procedures for ordering and administering vaccine...The Resident...will complete the Flu Consent Form...prior to the administration of the vaccine...Offer the resident...a choice as to whether or not he/she wants to have a flu shot...."			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

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